

CALIFORNIA AND WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 47

AUGUST, 1937

NO. 2

California and Western Medicine

Owned and Published by the
CALIFORNIA MEDICAL ASSOCIATION

Four Fifty Sutter, Room 2004, San Francisco, Phone DOUGLAS 0062

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Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

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Advertising Representative for Northern California
L. J. FLYNN, 544 Market Street, San Francisco (DOUGLAS 0577)

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Subscription prices, \$5 (\$6 for foreign countries); single copies, 50 cents.

Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

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Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

UNITED ACTION: BY THE PROFESSIONS OF MEDICINE, DENTISTRY AND PHARMACY

"Fraternal Greeting Delegates."—Proceedings, from time to time, of the annual sessions of state medical associations record fraternal greetings, as expressed by representatives from neighboring states; and such felicitations make for solidarity, a unity of effort in the attainment of organization and other results, always mutually desirable. Good, however, though the maintenance of such interchange of opinion may be, an equally important series of contacts are those which can be made with members of the dental profession (who, in one sense, from both the standpoint of professional training and their work, also are doctors of medicine, specializing in a very definite and important field in oral hygiene and surgery), and with members of the pharmaceutical profession (whose forebears included many of the "barber-surgeons" of earlier days, and whose interests are still likewise most intimately related to medical practice).

In the domain of the public health, then, physicians, dentists and pharmacists all have heavy and interlocking responsibilities, as witness in infectious diseases, focal infections, food and drug, and also narcotic violations.

* * *

Medical, Dental and Pharmaceutical Professions Are Well Organized; They Should Pool Their Efforts.—Each of these three professions is well organized, and, in certain activities, each excels the others in well-planned and effective work; wherefore, more intimate contacts, one with the other, and each with the other two, could be made to be of value, not only to the professions themselves, but to the state and its citizens who are to be served.

Another thought to be kept in mind is this: Practically every citizen in California, and other commonwealths, too, at some time or another, has dealings with either a physician, a dentist or a pharmacist; these relationships being often of a peculiarly important and personal nature, needing as their basis mutual confidence and friendship. The existence of this psychologic foundation

†Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

should not be underestimated, because, if these learned professional groups with mutual interests pool their joint efforts in civic and legislative matters, it is questionable whether any important matter in which they are jointly concerned could go down to defeat, either in legislative halls or through the general election ballot.

* * *

Twenty-five Thousand Professional Men Can Mold Public Opinion.—In California, the licensing boards in medicine, dentistry and pharmacy have on their registration rolls some 9,000 physicians, 6,000 dentists, 9,100 pharmacists and 1,300 assistant pharmacists, or in all about twenty-five thousand professionally-trained men and women, which, in a state with more than five million citizens, may seem only a minority group. So it is, in numbers; but in capacity for influence, this limited professional aggregation could probably mold public opinion more easily than any other similar number of persons, no matter to what vocations, in what business or other activities they might belong.

* * *

October Conference of Officers and Committeemen Should Consider This Subject at Fresno.—We present this thought as worthy of careful consideration by the officers and members of these three respective professions, each of which, in recent years, has suffered attacks from special interests, resulting in battles which might have been fought to a more successful conclusion had the united strength of the three professions of medicine, dentistry and pharmacy been brought into play.

* * *

California Medical Association By-Laws Provide for a "Contact Committee."—When the present Constitution and By-Laws of the California Medical Association were adopted at Coronado in May, 1929, one of the new standing committees provided for was the "Committee on Associated Societies and Technical Groups"; and it may be well to quote Section 16 of Chapter V of the By-Laws, to note what it states concerning the functions of this committee:

Chapter V, Section 16.—The Committee on Associated Societies and Technical Groups, subject to the instructions of the Council, shall endeavor to create proper liaisons between this Association and other state and national medical organizations, as well as with the organizations of related professions, such as dentistry, pharmacy, and nursing. It shall also endeavor to bring about a proper understanding with nonmedical organizations or groups of technicians and others whose work has a bearing on, or is related to, the practice of medicine.

It is to be hoped, therefore, that the present committee, consisting of Dr. John V. Barrow of Los Angeles, Dr. William H. Geistweit of San Diego and Dr. Edwin L. Bruck of San Francisco, will be able to make a progress report concerning its work at the Fresno meeting in October of State Association officers, county society secretaries and members of standing committees, that will be of highest interest and value to all concerned.

Fraternal Delegates to These Associated Professions.—Why, also, would it not be good policy for the California Medical Association to have a standing rule to send fraternal delegates each year to the annual sessions of the California State Dental and Pharmaceutical Associations?

It might be advisable, in addition, to make provision for a conjoint session of the legislative committees of the three professions, to discuss pending and prospective laws. Each group could hold its own meeting part of the day, but a brief general session, say from 11 to 12:30 noon, with luncheon to follow, could go far in making for better understanding and agreement on efforts that should be coordinated.

The changing times and the many onslaughts by social and other theorists necessitate new lines of offense and defense in professional practice. Proper union between the members of the medical, dental, pharmaceutical, and also the nursing professions would go far in making for better protection of the public health, and at the same time aid materially in the maintenance of professional standards and aims.

CALIFORNIA "MIGRANTS": "WORKERS" AND "ROVERS"

A New California Problem.—During the several years just passed, a new social, public health and economic problem has forced itself upon the attention of state, county and municipal officials of California. It has to do with migratory workers, or "migrants," as the daily press is beginning to designate them. Because these transient laborers—some merely "rovers" in search of a kindlier climate and environment, and an easier mode of living—are often almost without financial means, compelling them to live under crowded and unhygienic conditions, their presence in a community early and necessarily attracts the notice of state and local public welfare and health officials; and later, the mounting costs of the physical care and relief needed by these indigent or near-indigent transients make such inroads upon state and local funds as to challenge the attention of administrative officials.

* * *

Articles in This Issue.—In this issue of the Official Journal will be found some press clippings and other articles* giving illuminating information on the bigness of this California problem; a matter, indeed, so serious, in these days of economic stress and strain, that it has at last taken on special importance for taxpayers as well as state and local officials.

The article and letter, for example, by Director Dickie indicate the manner in which the State Board of Public Health is drawn into the picture, both from the demands of preventive and also of curative medicine; the latter called for when persons of insufficient residence in California are not eligible to admission to county hospitals, it then

* See, for press clippings, page 141; for article on migratory workers, page 106; for letter, page 131.

becoming necessary for state and local health authorities to step in, both to give emergency medical care and to prevent the spread of infectious diseases. The extent of the economic phases will be better understood, after perusal of the rising relief costs in one county of the state, that of Los Angeles.

* * *

Responsibilities of Respective County Medical Societies.—In counties in which these "migratory camps" come into being during different periods of each year, the component medical societies may serve their respective communities in good wise, through the appointment of special committees to make surveys and reports on how best to bring about efficient cooperation with local public health agencies and other officials.

* * *

Federal Cooperation Is Also Indicated.—Here, also, we deal with not an intrastate, but rather an interstate problem; wherefore, in good time, federal cooperation and support must likewise be forthcoming. Some of the press clippings take up this phase of the problem.

"GOVERNMENT MEDICINE"

"Los Angeles Times" Prints a Sound Editorial on Senator Lewis' American Medical Association Address at Atlantic City.—The address of Senator James Hamilton Lewis of Illinois, made at the Atlantic City meeting of the American Medical Association and printed in the *Journal of the American Medical Association* proceedings of the House of Delegates, has become the basis of much comment, particularly so because of the vagueness of some of the Senator's statements.

From later accounts, it would appear that Senator Lewis spoke, not in the name of President Roosevelt, but as a "friend of both the Federal Administration and the Medical Profession." For his kindly advice, physicians should be appreciative, even though they fail to accept many of his premises and conclusions. His remarks were discussed in both the medical journals and the press in general; and an editorial, with the caption, "Government Medicine" (reprinted on page 141, in this number), which appeared in a recent issue of the *Los Angeles Times*, is given place because it brings out some very sensible points. Its perusal, consequently, is commended to our readers.

NEW PUBLIC HEALTH LAWS

New Laws Become Operative on August 27, 1937.—On August 27, the statutes approved by the Legislature and signed by Governor Merriam become laws. In previous issues comment was made on proposed laws. Some of these failed to receive legislative approval, others were given "pocket" or direct vetoes by the governor, or signed by him, these last to find places on the statute books.

Many members of the Association, during the recent legislative session, gave much appreciated aid when called upon by the California Medical Association Committee on Public Policy and Legislation; and for them and other readers the comments which follow are hereby presented.

* * *

Laws Relating to the Medical Practice Act.—From the report of the Law and Education Committee of the California Board of Medical Examiners, Charles E. Schoff, M. D., chairman, we quote:

On June 24, 1937, the records of the Secretary of State's Office show the following bills, in which the Board of Medical Examiners has been interested during the last legislative session, to have been signed by the Governor and chaptered:

Senate Bill 133 (Code bill—companion to Assembly Bill 880); signed June 17, 1937. Now Chapter 414, Statutes 1937.

Senate Bill 252—Provided funds for a building for this department in Sacramento; signed May 12, 1937. Now Chapter 288, Statutes 1937.

Assembly Bill 880 (Code bill—companion bill to Senate Bill 133); signed June 16, 1937. Now Chapter 399, Statutes 1937.

Assembly Bill 1005—Added Section 581 to the Business and Professions Code re diploma mill; signed June 17, 1937. Now Chapter 446, Statutes 1937.

* * *

Assembly Bill 1004 (Received Pocket Veto)—Proposed to amend Section 2380 of the Business and Professions Code, prohibiting "the actual practicing of any system or mode of treating the sick or afflicted which is intended or has a tendency to deceive."

Assembly Bill 1253 (Received Pocket Veto)—Among other provisions prohibited dispensing, prescribing or selling of dinitrophenol for therapeutic purposes.

Senate Bill 782 (Received Pocket Veto)—Added the following sections to the Business and Professions Code: (a) required appellant to pay cost of appeal, (b) included under the heading of "unprofessional conduct" the "fraudulent representation by advertisement or otherwise that a manifestly incurable condition of sickness, disease, deformity, ailment, or injury of any person can be cured. . . ." (c) knowingly making or signing any false certificate while acting in a professional capacity, or while acting within the scope of practice permitted by the certificate issued.

Senate Bill 783 (Received Pocket Veto)—Amended Section 2436 of the Business and Professions Code providing for injunction.

Senate Bill 1139 (Received Pocket Veto)—Amended the so-called college incorporation bill passed in 1927 (Chapter 152, Statutes 1927).

* * *

California State Board of Public Health.—A résumé of legislation relative to public health enacted by the Legislature of 1937, and receiving the Governor's approval, includes the following:

Assembly Bill 2790, now known as Chapter 787, Statutes of 1937.

This Act provides for the establishment in the State Department of Public Health of a Bureau of Venereal Diseases whose function it shall be to "coöperate for the prevention, control, and cure of venereal diseases with physicians and surgeons, medical schools, public and private hospitals, dispensaries, clinics, public, and private schools, colleges, normal schools, university authorities; federal, state, local, and district health officers and Boards of Health and all other authorities; institutions caring for the insane; and with any other person, institutions or agencies."

It gives the State Board of Public Health power to " . . . make and promulgate such rules and regulations as

are reasonably necessary to effect the control of venereal disease . . . and such rules and regulations as are reasonably necessary to control and effectuate a proper reporting, quarantine, examination of, and proper control measures for such diseases." It further provides that "it shall be incumbent upon a State agency conducting a public hospital to admit acute venereal disease cases when, in the opinion of the State Department of Public Health or the local health officer having jurisdiction, such person infected with venereal disease may be a menace to public health."

To provide for the enforcement and support of the provisions of this Act the sum of \$150,000 was appropriated for the eighty-ninth and ninetieth fiscal years.

Assembly Bill 1721.

This Act provides that the sale and distribution of prophylactics shall be under regulation of the State Board of Pharmacy. It provides for the licensing of wholesalers and retailers. It provides standards for definite types of prophylactics, and further provides that all prophylactics must bear the manufacturer's name, address, and trademark. The Act further makes it unlawful to publicly advertise the sale or uses of prophylactics on "placards, billboards, hand bills, newspapers, periodicals, or other printed matter, or by radio"; but does not prohibit the advertising in medical or drug publications.

Assembly Bill 1132.

Adds Chapter 11a—Section 11491 to 11519 to Part 2 of the Insurance Code—and repeals Chapter 386 of the Statutes of 1935.

1. Applies only to nonprofit hospitals, and nonprofit hospital services.

2. Hospitals shall incorporate under provisions of this Chapter and Division One, Part IV, Title XII of the Civil Code.

3. At least two-thirds of the Board of Directors shall be representatives of the hospital with whom the hospital service has contracts and licensed physicians.

4. All hospitals with whom a hospital service contracts in the State of California must be licensed by the State Department of Public Health.

5. The State Department of Public Health shall inspect all hospitals before issuing a certificate.

6. The fee for inspection and a certificate of approval shall be not more than 25 cents per bed, but not less than \$15 per hospital.

7. The State Department of Public Health shall have the power to enforce the provisions of this Act and regulate and enforce the hospital standards of this Act.

8. The State Department of Public Health may hold hearings on complaints against any licensed hospital. The certificate of approval may be revoked. In such case the department shall notify the Commissioner of Insurance. He then shall revoke the certificate of authority of the hospital.

9. The Commissioner of Insurance shall not issue a certificate of authority to any nonprofit hospital service unless:

- (a) The hospitals contracted with have certificates of approval from the State Department of Public Health.
- (b) The contract with subscribers is free of fraud.
- (c) That no profit can be made from contracts, fees, etc.

Senate Bill 118.

1. Licenses may be issued—

- (a) Technologists—
 - 1. By examination.
 - 2. All those engaged in direction of a laboratory for a period of five years prior to this Act.
- (b) Technicians—

- 1. By examination.
 - (a) All sciences.
 - (b) One science only.
- 2. Any person who, for three years during past five years has been engaged in performing clinical laboratory tests in California.

2. Laboratory supervised by a licensed technologist or M. D.

3. All technicians must be licensed by State Board of Public Health.

4. Apprentices in laboratories are allowable.

5. Persons employable—

- (a) Licensed technologists and technicians only employable after January 1, 1938.
- (b) Apprentices can be employed only in a laboratory in which there are licensed technicians.
- (c) Unlawful for more than two apprentices to be employed in one laboratory.

6. Laboratories in nonprofit hospitals, State hospitals, or United States hospitals exempt.

7. Fees—

- (a) License fee of not exceeding \$10 for each technologist and not to exceed \$5 for each technician.
- (b) Finances reportable monthly by Board to State Controller and biennially to Governor.
- 8. State Board may make rules and regulations for enforcement of Act.

Concerning the above discussed Senate Bill 118, the following report may also be of interest:

COPY

June 17, 1937.

Report on Senate Bill No. 118—Parkman:

Subject: New act, licensing clinical laboratory technologists and technicians, and regulating the conduct of clinical laboratories.

Form: Approved.

Constitutionality: Approved.

Analysis:

This act is substantially the same as Deering Act 4814a, Chapter 638 of the Statutes of 1935. This 1935 Act was held unconstitutional by the Attorney General, and the bill repeals this 1935 enactment and provides another statute without the unconstitutional feature.

The bill declares that it is unlawful, after January 1, 1938, for any person to conduct a clinical laboratory or to perform tests in such laboratory unless he is licensed as a clinical laboratory technologist or as a clinical technician or as a physician and surgeon. (Secs. 1 and 5.)

The State Board of Public Health is to issue certificates to qualified technologists and technicians after examination to ascertain their fitness to practice. Technologists who have practiced five years, and technicians who have practiced three years may be licensed without examination if they file their application prior to January 1, 1938. (Secs. 4 and 5.)

The bill exempts clinical laboratories operated by nonprofit hospitals, and by nonprofit hospitals which are maintained by employers for their employees and their dependents. It also exempts clinical laboratories operated by the State or Federal Government, and those operated by nonprofit foundations engaged in research work. (Sec. 6.) The bill does not require physicians and surgeons to be licensed in order to conduct a laboratory or to perform tests. (Sec. 4.)

A fee of not to exceed \$10 is provided for the original application and the annual renewal of a technologist's license, and a fee of not to exceed \$5 is provided for the original application for a technician's license, and of not exceeding \$1 for the annual renewal of a technician's license. All money collected is deposited in a special fund and appropriated for meeting the costs of enforcing the act. (Sec. 8.) FRED B. WOOD, Legislative Counsel.

Senate Bill No. 425 now known as Chapter 758, Statutes of 1937.

This is "An act to license, regulate and control the manufacture, transportation, sale, purchase, possession, and disposition of alcoholic beverages; to levy an excise tax on the sale of alcoholic beverages; to provide for the licensing of the manufacture, distribution and sale of alcoholic beverages; to prescribe penalties for the violation of this act;

to promote temperance in the use of alcoholic beverages; to adopt and enforce unfair trade practice regulations and price-fixing provisions regulating the sale of alcoholic beverages; to take effect immediately."

In section 37, item 3 of this Act, the sum of \$60,000 is appropriated "... to be used by the State Department of Public Health for enforcement work directed toward preventing the manufacture, sale, or transportation of adulterated, misbranded, or mislabeled alcoholic beverages."

This Act allows the Bureau of Pure Food and Drug Inspection to continue the work of enforcement of the regulations of the 1935 Act on manufacture, sale, or transportation of adulterated or misbranded alcoholic beverages.

Assembly Bill 116, Chapter 769, Statutes of 1937.

This bill appropriates the sum of \$50,000 to be expended by the State Department of Public Health for the enforcement of standards, quality and identity in the manufacture and sale of California wines and brandies.

Assembly Bill 2058, now known as Chapter 777, Statutes of 1937.

This Act amends Section 1144 of the Agricultural Code pertaining to the regulation by the State Department of Public Health of eggs shipped into the State of California from other states or from another country.

It provides:

1. That a statement be sent the Department of Public Health as to the quality, kind, and containers of egg products shipped into the United States.

2. That a statement showing the person or firm to whom such egg products are sold be furnished the State Department.

It further provides that cold storage warehouses furnish the department at the end of each month a statement of all foreign imported eggs received during the month, with the name of the depositor, the quantity of such egg products, and the containers used. Further, that such foreign imported egg products shall be inspected by the department before removal. An appropriation of \$2,400 was made to the department for the enforcement of this act.

TWO INTERESTING DECISIONS OF THE A. M. A. JUDICIAL COUNCIL BEARING ON APPEALS AGAINST DISCIPLINARY ACTION IN CALIFORNIA

Appeal from Disciplinary Action of Two Component County Societies.—Del Monte Session minutes* make brief reference to disciplinary action by two component county societies of the California Medical Association taken against certain respective members; the members so adjudged refusing to accept the verdicts, and presenting appeals, first to the Council of the California Medical Association for reversal of county society action and, when not granted by the State Council, then to the Judicial Council of the American Medical Association for reversal of judgment or a rehearing.

Space does not permit the printing of the full decisions of the American Medical Association Judicial Council in the matter of these appeals, but it may be of interest to members to peruse excerpts on some of the general principles involved, as handed down by this national committee. The particular decisions in question, as given by the American Medical Association Judicial Council and transmitted to the California Medical Association

under date of April 24, refer to disciplinary procedures previously considered by the Council of the California Medical Association in connection with actions taken by the San Francisco and Kern County Medical Societies.†

* * *

Excerpts from the Decision of the Judicial Council of the American Medical Association in the San Francisco Cases.—From the decision rendered in the San Francisco cases, we quote:

The appellants in this case were charged with a violation of certain sections of the Principles of Professional Conduct of the San Francisco County Medical Society, were found guilty and sentenced to various degrees of punishment. Appeal was taken to the Council of the California Medical Association. Before the appeal was heard certain of the group asked for a rehearing before the county society Board of Directors, which was granted and held, but none of the appellants appeared. At the rehearing, guilt was reaffirmed, but certain sentences previously meted were modified. . . .

The appellants came before the Judicial Council asking a reversal of the decision of the Council of the California Medical Association on the following grounds. . . .

... There was a voluminous mass of exhibits and testimony presented at the hearing before the Judicial Council. Exhaustive briefs were submitted and there was every evidence of thorough and aggressive preparation by astute legal minds on both sides. Every advantage was taken of technicalities and of errors of procedure. In analyzing and studying the material and the arguments the Council [American Medical Association Judicial Council] has had as its objective the determination as to whether or not the interpretation of ethical matters has been correct and whether or not the appellants have had a fair trial. . . .

... The Judicial Council [American Medical Association Judicial Council], after a thorough consideration of the general conditions of professional practice in San Francisco County as exhibited by the records, is of the opinion that the trial was as fair as could be had under the provisions of the constitution and by-laws of the County Society. It believes that, in fact, there was no discrimination or unfairness warranting a reversal of the action of the State Council. . . .

... The Council [American Medical Association Judicial Council] is not concerned with fine legal technicalities. Its function is to see that substantial justice to both parties in a controversy is done to one no less than the other. In the present instance the appellants were convicted of conduct stated to be unethical under the Principles of Medical Ethics, and their conviction was upheld by the Council of the California Medical Association. The Judicial Council expresses no opinion as to guilt or innocence, but guilt having been declared, the Council considers it a minor technicality as to whether the charges were brought under a county rule of conduct or under the American Medical Association's Principles of Ethics.

... In respect to the third contention of the appellants, that there was not sufficient evidence to show any violation of the Principles of Conduct of the San Francisco County Medical Society by the appellants or any of the accused, the Judicial Council is not in agreement with the sophisticated reasoning upholding the contention. As the guilt or innocence of the charge is the province of the county and state bodies, the Judicial Council [American Medical Association]

† See Council minutes as follows:

Volume 44, No. 2, February, 1936, pages 121 and 122; Volume 44, No. 5, May, 1936, pages 438 and 439; Volume 45, No. 1, July, 1936, pages 96 and 97; Volume 45, No. 5, November, 1936, page 431.

* See June, 1937, issue, CALIFORNIA AND WESTERN MEDICINE; for House of Delegates minutes, page 411; and for Council minutes, items 5 and 14, page 424.

sociation Judicial Council] has no further comment to make. . . .

... The Board of Directors [of the San Francisco County Medical Society] met to consider the report of the Grievance Committee and hear arguments from the accused. This meeting was attended by fourteen of twenty-one directors, and at this meeting the transcript of evidence being so voluminous (1291 typewritten pages) as to be impossible of reading and review by all members of the Board, a committee of five was appointed to read, review and report back to the Board. . . .

... The San Francisco County Medical Society defrayed the expense of eleven hearings during which the defense had the benefit of a transcript of its own sixteen witnesses. It now claims to have more material witnesses. If it had more witnesses who were material, the defense was privileged to provide a stenographer as the Society had done up to its ability. Reading this transcript through its 1291 pages, the Council [American Medical Association Judicial Council] has some question as to the material nature of the further evidence the accused desired to present. It would seem that sixteen witnesses should be a sufficient number to controvert the charges if they could be controverted. . . .

... The Judicial Council [American Medical Association Judicial Council] finds no reversible error or injustice in this case and, therefore, sustains the decision of the Council of the California Medical Association. . . .

April 5, 1937.

Quotations from the American Medical Association Council's Decision in the Kern County Cases.—Following are some excerpts on the Kern County appeal:

... The appellants in this case were charged with unethical conduct in that they had been and were at the time violating Chapter III, Article VI, Section 2, of the Principles of Medical Ethics of the American Medical Association; Section 4 (second paragraph) Chapter I of the by-laws of the California Medical Association; and subdivision (b) of Section 1 of Chapter I of the by-laws of the Kern County Medical Society by disposing of their services under conditions that make it impossible to render adequate service to their patients and interfere with reasonable competition in the community. They were tried according to the procedure set forth in the by-laws of their society, found guilty as charged and sentenced to expulsion from and various terms of suspension of membership. The disciplined members appealed to the Council of the California Medical Association as duly provided in the California Medical Association's by-laws, which Council heard their appeal and confirmed the action of the Kern County Medical Society except as to a modification of the periods of suspension. The appellants then carried their appeal to the Judicial Council of the American Medical Association alleging . . .

... As provided in the by-laws of the American Medical Association this Judicial Council [American Medical Association Judicial Council] does not consider nor express any opinion as to the guilt or innocence of the appellants as charged, except in so far as a question of interpretation of the Principles of Medical Ethics is concerned. Its duty is confined to a consideration of the law and procedure to assure an accused a proper and a fair trial, and to an interpretation of the Principles of Medical Ethics.

As to procedure the Judicial Council finds no major error. The charges are drawn with great care and much detail. The accused could not be so ignorant of the charges as to be unable to prepare and present such defense as they might have. Although the appellants were given every opportunity to appear and defend themselves they chose not to appear but to depend upon a written blanket denial of the charges, legal technicalities, and a charge of prejudice

against their judges. Physicians are not lawyers nor are they trained in the law. The constitutions and by-laws of their societies and the Principles of Medical Ethics are not worded nor are their rules of procedure adopted with the intention of allowing minor technicalities or sophisticated argument to prevent justice or interfere with the high ideals inherent in the practice of medicine. The claim of the appellants of irregularity in the charges is not upheld.

The claim of prejudice against them on the part of their judges is a claim only and not supported at any point by evidence in the record. . . .

... The appellants contended . . . that as they were neither charged with nor were practicing "contract practice" they had not violated the section. In interpreting this section, as is true of all other sections, it must be borne in mind that the Principles of Medical Ethics are, in fact, principles as distinguished from laws. Principles are the bases upon which laws are written. They are basic and general in character. They are not to be evaded by sophistry nor held to specific wording. Laws are based on principles as applied to particular acts or conditions. They are specific in their application and definite in their language. A fair example are the laws governing assault, assault and battery, mayhem, manslaughter, and murder. These laws all vary and are very specific in their provisions, but all are based on the principle that it is wrong physically to harm another. Such laws may be and often are circumvented or evaded by technicalities, but principles may not. In the section quoted under the heading of "contract practice," first there is stated the broad general principle applicable to all medical practice that "It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians." Following this broad principle, because contract practice is by far the major method of practicing which may need this general principle to be expressed, is a definition of what is considered to be "contract practice." This definition is specific in its wording—as it should be—and until changed by action of the House of Delegates specifically limits the application of the term "contract practice" to words of the definition. It should be noted that there is no definition of what is an ethical "contract," for it would be impossible in being specific to cover all contingencies and close the door to all evasions of the specific language used. . . .

... The appellants were charged on four counts. It is not necessary that they be found guilty on all four counts to exercise disciplinary measures. To be found guilty on one count is sufficient to impose disciplining suitable to the degree of guilt proved. The Judicial Council considers that the punishment decreed does not exceed the merit of the case. The decision of the Council of the California Medical Association affirming in part orders entered by the Kern County Medical Society . . . is sustained.

The broad and fair spirit in which the five members of the Judicial Council of the American Medical Association (Lloyd Noland, Fairfield, Alabama, 1937; John H. O'Shea, Spokane, Washington, 1938; Edward R. Cuniffe, New York, 1939; George Edward Follansbee, chairman, Cleveland, 1940; Walter F. Donaldson, Pittsburgh, 1941; Olin West, secretary ex officio, Chicago) approached their work is evident when the above excerpts are read.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 117.

EDITORIAL COMMENT[†]

RELATION OF VITAMINS TO IMMUNITY

It is apparently axiomatic to commercial advertisers that the oral administration of vitamin preparation or the ingestion of foods with high vitamin content increases the "vitality" of normal individuals, and that this increased "bodily vigor" must necessarily manifest itself by an increased resistance to infectious diseases. This intuitive belief is definitely stated or implied in numerous current commercial advertisements. Few exploiters of vitamin-rich foods, however, realize that this belief is as yet unsupported by adequate experimental evidence. The experimental studies recently reported by Doctor Jusatz¹ of the Hygienic Institute, Marburg, Germany, are perhaps prophetic of the type of evidence to which commercial interests must in time adjust their advertising policy.

In order to test the effects of vitamin deficiencies on immunologic functions, the German serologist fed growing rabbits on routine laboratory diets which had been rendered vitamin-free by prolonged pressure-cooking at 120 degrees centigrade. Rabbits thus fed were invariably arrested in their normal growth, and usually remained at a fairly constant subnormal weight for four or five months. Serological examination showed a subnormal bactericidal titer (*Staphylococcus aureus*) in the blood serum of these stunted rabbits. Of even greater significance the stunted rabbits were unable to produce specific antibodies of normal titers, precipitins being produced of only 10 per cent the titer of those produced in control normal rabbits. Thus far, Jusatz's data confirm the advertised claims that vitamin deficiencies cause a lowering of normal antimicrobial resistance.

The therapeutic effects of commercially available vitamins were tested by Doctor Jusatz on these immuno-deficient rabbits. Fat-soluble vitamin A was administered orally in the form of commercially available "Vogan" (Merck); water-soluble vitamin B-complex given in the form of dry yeast, "levurinosé"; and water-soluble vitamin C either as a native ascorbic acid recrystallized from paprika or as commercially available synthetic ascorbic acid, "redoxon." Doctor Jusatz found that the daily addition of any one of these preparations to his heat-denatured diets had no demonstrable beneficial effect on the bactericidal titer of his stunted rabbits. Nor did such additions give any demonstrable serologic benefits to control normally fed rabbits. Given orally in adequate doses over long periods of time, these vitamins did not enable his deficiency rabbits to produce specific precipitins of normal titers. The widely advertised immunotherapeutic claims of

these vitamins in deficiency diseases, therefore, were not confirmed by his experiments.

Tests with commercially available fat-soluble vitamin D ("Ergosterin," Merck) gave even more discouraging results. Daily feedings (or intragastric injections) with recommended doses of "ergosterin" led in about half of his stunted rabbits to a transient rise in the bactericidal titer of the blood serum. This improvement lasted about seven days. After the seventh day all of his rabbits showed a gradual or even rapid fall in bactericidal index. A new and apparently permanent low level was established by the twenty-first day. In most cases this was approximately half of the average titer in his untreated deficiency rabbits. This vitamin D suppression of titer even below the previous deficiency level was attributed by him to a beginning D-hypervitaminosis. Vitamin D also depressed the subnormal power of his deficiency rabbits to produce specific antibodies.

Clinicians will challenge Doctor Jusatz's conclusions as presumably inapplicable to the relatively mild vitamin deficiencies of human medicine. His results, however, cannot fail to place numerous commercial interests on the defensive.

Box 51.

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Stanford University.

SULFANILAMIDE IN THE TREATMENT OF GONORRHEA

In view of the recent publicity in the lay journals and metropolitan dailies regarding the administration of sulfanilamide for gonorrhea, it should not be amiss to comment briefly thereon.

Until the advent of the ketogenic diet, now almost supplanted by the use of mandelic acid, the value of urinary antiseptics, administered either orally or parenterally, was questionable.

We now have two agents of undoubted value in the treatment of many urinary and some genital infections. From clinical observations it would seem that mandelic acid is efficacious by reason of imparting bactericidal and bacteriostatic properties to the urine, but its use is contraindicated in urinary tuberculosis and in gonorrhea.

Colston of Johns Hopkins is authority for the statement that the urine of patients taking large doses of sulfanilamide is not bactericidal, notwithstanding the truly marvelous therapeutic results he claims to have observed in the treatment of acute gonorrhea by this agent.

On the other hand, Helmholz and his coworkers demonstrated that the urine of patients taking it was decidedly and unmistakably bactericidal for *Escherichia coli* and *Aerobacter aerogenes*, and for certain strains of *Staphylococcus aureus*, *Streptococcus faecalis*, *Proteus vulgaris* and *Pseudomonas aeruginosa*.

When employed for subacute prostatitis of gonorrheal origin, prompt and decided improvement in several patients has been observed by a number of my close colleagues and myself. This improvement is so striking that the drug would

[†]This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

¹Jusatz, H. J.: Ztschr. f. Immunitätsforsch., 88:472, 483, 1936.

seem to function through the capillary or lymph stream in addition to the bactericidal action of the urine. It would seem impossible for a purely bactericidal urine to produce such results, since such infections of the prostate could not possibly be reached by bactericidal urine alone. This hypothesis is in keeping with the experience of many clinicians in Europe and America employing sulfanilamide for the varied infections caused by B-hemolytic streptococci. Thus this seeming fact provides us with an agent heretofore almost lacking.

Our clinical experience, although limited, seems to demonstrate the following, viz.:

1. In about 20 per cent to 25 per cent of the cases of acute gonorrhea, with oral administration of sulfanilamide, prompt and spectacular therapeutic results ensue.

2. In perhaps 25 per cent more, the clinically observed results are definite and decided.

3. In the remainder, its efficaciousness is difficult to demonstrate.

4. Except in the class above noted, where improvement is prompt, definite and decidedly marked, orthodox treatment (in conjunction with sulfanilamide), should not be neglected.

5. There seems much promise in the use of this synthetic in the treatment of gonorrheal arthritis.

6. For the present, the dosage of forty grains per diem should seldom be exceeded except in desperate cases. For gonorrhea, it is wise to begin with the smaller dosage and increase, rather than the large initial amounts advocated by most authors for severe types of streptococcus infections.

7. With moderate dosages we have so far noted no very serious toxic effects, and no blood dyscrasias have occurred; nevertheless, a most careful watch should be had for any toxic manifestations. These manifestations are dizziness, anorexia, malaise, muscular weakness, and even marked mental confusion occasionally with maximum dosage. If such toxic symptoms are encountered, the drug should be promptly discontinued temporarily or permanently.

1913 Wilshire Boulevard.

ROBERT V. DAY,
Los Angeles.

INFANT MORTALITY IN SAN FRANCISCO

For the year 1936 the infant mortality rate in San Francisco was 42 per 1000 live births. This was an increase of 6.7 over the year 1935 which showed a rate of 35.3. In 1935 infant deaths comprised 2.9 per cent of the total deaths, whereas in 1936 the infant mortality was 3.3 per cent of total deaths, showing both an actual and relative increase. For the past ten-year period the average infant mortality rate is 41, ranging from 49 in 1927 and 1929 to an all-time low rate of 33 in 1934. While the rate of 42 in 1936 still comes within the standard deviation, which may normally be expected, an analysis of the causes of death for the two years of 1935 and 1936 presents some interesting comparisons.

Principal Causes of Infant Deaths

Cause of Death	1935	1936
Atelectasis	23	6
Bronchopneumonia	15	27
Congenital heart malformation	17	22
Enteritis (under 2 years).....	5	20
Injuries at birth (without Cesarean)	15	23
Lobar pneumonia	2	10
Other congenital malformation	14	10
Prematurity	108	108

By far the greatest single cause of death was prematurity, which was identical for the two years. Atelectasis showed a marked decrease in 1936, a fact which, perhaps it might be said, reflects an improvement in prenatal and obstetric care. This latter, however, is not borne out by the significant increase in injuries at birth in 1936 over 1935, the term "injury," of course, having a very broad interpretation. The only other cause of death to show a decrease in 1936 was listed under congenital malformation other than heart. No significance may be attached to this finding. The greatest increase in 1936 was found in bronchopneumonia, with 27 deaths as against 15 in the year before, and 10 deaths from lobar pneumonia as against 2 in 1935. Altogether an increase of 20 pneumonia deaths, proving the private physicians' impression that 1936 was a "respiratory year" to be correct. Another significant increase was from enteritis. Most of these deaths occurred during an institutional outbreak, which was not reported to the Health Department until near its termination. With a total of 52 more deaths in 1936 than there were in 1935, 35 may be accounted for by pneumonia and enteritis alone. The remaining increase is disseminated throughout the other causes of death, one more here and one more there, without any significant distribution.

Conclusions.—Most of the increase in the infant mortality rate in San Francisco may be accounted for by the increased incidence of respiratory diseases in 1936 and a localized outbreak of enteritis in a children's institution.

Office of Director of Public Health.

J. C. GEIGER,
P. S. BARRETT,
San Francisco.

Repellants Against Mosquitoes.—All repellents directed against mosquitoes have one common drawback: the most efficient ones are highly volatile and their effect rapidly wears off. A successful repellent, besides being obnoxious to the mosquito, should have the following requirements: it should have a base that will retard rapid volatilization of the active principle, it should spread readily, and it should have such a consistency that it will adhere to the exposed body surfaces. Of the large number available the most satisfactory formula is probably oil of citronella 15 cubic centimeters (one-half ounce), spirit of camphor 7.5 cubic centimeters (one-fourth ounce), cedar-wood oil 7.5 cubic centimeters, and white petrolatum 60 grams (two ounces). The use of a phenol soap for washing may be of aid. For lawn parties or open-air gatherings, frequent undertable sprayings with Flit or any of the antimosquito sprays insures comfort for a considerable time.

ORIGINAL ARTICLES

THE UTERINE CERVIX: ITS DISORDERS AND THEIR TREATMENT*

By NORMAN F. MILLER, M.D.
Ann Arbor, Michigan

PROBABLY the full significance of the trite old saying, "An ounce of prevention is worth a pound of cure," has not yet been fully realized so far as the uterine cervix is concerned. The physician looking at the cervix should see more than just a simple lesion. He should see future disease often foreshadowed by the minor disorder before him. While there are a great many things about common lesions of the cervix that are poorly understood, this need not influence our practical attitude toward them. Time and research will likely alter our ideas, but until that time arrives existing evidence justifies reasonable concern over their presence and correction.

CLASSIFICATION

While much has been written regarding cervical disorders it is pertinent to our discussion that we briefly review these lesions, particularly their accepted cause and histopathology. Generally listed among common disorders of the cervix are:

1. Cervicitis (acute and chronic).
2. Erosion.
3. Cystic change.
4. Cervical polyp.
5. Laceration.
6. Eversion.
7. Leukoplakia.

By separately naming the disorders we imply distinct disease, each with its etiology and individual histopathology. Existing knowledge, however, suggests that this is incorrect. Bacterial trauma is likely to be an important etiological factor, and there is evidence to show that glandular dysfunction may also play an etiological rôle. However, such cause-and-effect relationship remains to be proved. Generally speaking, infection of the cervix is probably at the root of more evil than has generally been conceded in the past.

CERVICITIS

In acute cervicitis the inflammatory process is at first limited to the glands lining the cervical canal gradually spreading to the point where there is extensive and deep-seated involvement. Clinically, acute cervicitis is easily recognized, for the purulent or mucopurulent discharge coming from the cervical canal is a familiar picture. Less readily appraised are the chronic cases where the external appearance is nearly normal and gives rise to little cause for concern. The amount of discharge may not be great nor sufficiently purulent to excite in-

terest, yet chronic cervicitis is very common and unquestionably the source of much physical suffering. The physician would do well to view cervicitis as exhibit "A" among common disorders of the cervix.

EROSION

Trauma, actual, bacterial or chemical is generally thought to cause cervical erosion. Many observers place preëxisting cervical infection in the leading rôle in this connection. I believe erosions likely to be of endocrinal origin, but these unsettled questions need not confuse us in our more practical consideration of the subject. Erosions are common and easily recognized as the reddish area surrounding the cervical os. The first stage of an erosion is said to be the result of cervical infection (?) which leads to maceration and superficial slough of the squamous epithelium surrounding the external os. Actually and for a short time there may exist a true erosion. This first stage of depithelization is presumably replaced by columnar epithelium similar to that lining the cervical canal where it continues until the environment or something else again predisposes to the return of squamous epithelium. The source of the columnar epithelium is open to controversy, but generally it is thought to be derived from the cervical glands. With subsidence of the cervicitis or disappearance of the causative factors, the second stage, clinically characterized by the red-appearing columnar epithelium, gives way to squamous epithelium once more, the so-called healing of an erosion. A great deal of significance is attached to this interplay of epithelia in the development of cervical cancer.

CYSTIC CHANGE

Healing of an erosion seldom obliterates all evidence of its previous existence. Glands developed as part of the lesion on the vaginal surface of the cervix are either plugged by colepithelium or otherwise have their ducts occluded in the healing process. In either case the glands, unable to discharge their content, become distended and clinically appear as small pearly bodies which, when ruptured, discharge a thick tenacious mucus. Actually this cystic cervix is but a late phase of a preëxisting erosion. For clinical purposes, however, it is easier to designate the condition by the term cystic cervix which, after all, clearly describes the lesion at this stage. In evaluating these cysts it should not be forgotten that the visible cysts are but a part of the process, and that similar gland changes also occur in the deeper tissues of the cervix. It requires no stretch of imagination to realize how extensively the neck of the uterus may come to be altered by the changes described.

CERVICAL POLYPS

Adenomatous polyps of the cervix are common sequelae to chronic irritation and particularly infection. The polyp is readily recognized on speculum examination, but may easily be missed on digital examination alone, a point to be remembered in making a study of any woman's pelvis. They vary in size from tiny pinhead tumors to structures measuring three to four inches in length,

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Guest-speaker address given at the first general meeting of the California Medical Association during the sixtieth annual session, Del Monte, May 2-6, 1937.

and half an inch in diameter. Soft in texture, red in color and painless, they seldom undergo malignant change, but even so warrant microscopic study wherever possible. Their presence always suggests chronic irritation of inflammatory character.

LACERATION

While deep tears of the cervix and especially those associated with extensive scarring are clinically significant, the same concern cannot be said to apply to minor *healed* lacerations without extensive scarring. Lacerations may predispose to cervical infection, but aside from this there is scanty evidence to indicate that the average healed cervical tear does any harm. Doubtless much of the grief attributed to cervical tears in the past originated from other sources.

EVERSION

As the name implies, eversion or ectropion, as it is sometimes called, is merely a rolling out of the endocervium or mucous membrane lining the cervical canal. This condition occurs secondary to cervical lacerations, and except for the fact that by being so exposed it more readily becomes infected, the condition has no particular significance. Clinically it appears as a red area extending down from the cervical canal and involving only the central surface of the anterior and posterior cervical lips. It differs from an erosion in that there is actually no misplacement of epithelium. The deep reddish color is due to the columnar epithelium and its immediate underlying structures. Similar coloring, and for the same reason, is noted in an erosion.

LEUKOPLAKIA

This term is rather broadly applied to any area or spot of thickened epithelium on the cervix. Interest in this particular change is relatively recent, and may be attributed to the use of the colposcope in studying the cervix. Extensive leukoplakias are readily recognized clinically by the grayish-white appearance of the involved area.

COMMENT

These then are the common disorders of the cervix seen by physicians every day. Easily recognized, they do not always impress the practitioner with their probable significance. Too often he sees only the cervix and fails to recognize that a mucopurulent discharge from the cervical os is more than just a medical term—cervicitis. Indeed, unless the physician sees beyond the narrow limits of the disorder before him and envisions disease in its broader aspects—forecast perhaps by the insignificant-looking lesion before him, he is likely to fumble a great opportunity for prevention of disease in the female pelvis. We must recognize that the real importance of these common cervical disorders lies not so much in their existence as a local abnormality, but in their future potentialities.

SEQUELAE

To fully comprehend the significance of these lesions they should be weighed in the light of remote sequelae as follows:

1. *Cancer*.—Carcinoma of the generative tract is the most frequent form of cancer seen in the female, and cervical cancer heads this list. There is much about cancer that no one understands, and carcinoma of the cervix is no exception. In our attempt to evaluate common cervical disorders from the precancerous standpoint, let us avoid controversial matters as much as possible, and be guided by evidence generally accepted today. The increasing evidence pointing to a questionable relationship between common cervical disorders and cancer need not at this time influence our acceptance of such relationship. The tie-up between common cervical disorders and cancer may be summed up in a few sentences. Cancer probably does not begin in healthy tissue; it is local in its incipency, and there probably is a precancerous state even though we cannot, as yet, positively identify it. If we are willing to accept these statements, then there appears to be no good reason why these common disorders should not be viewed with suspicion—not alarm—and treated until cured. The simple yet generally-adequate measures for treating such disorders today, generally without inconvenience to the patient, no longer justifies indifference or watchful neglect. While not convinced of direct cause-and-effect relationship between some of these common cervical disorders and carcinoma, I still can see no good reason for their neglect. Therapeutic vacillation is bound to occur, but no physician should foster indecision regarding the advisability of clearing up any cervical disorder.

2. *Foci of Infection*.—In some respects the case against the infected cervix as a focus of infection is even more impressive. True, abundant direct data are again lacking, but the evidence is so strong that such relationship appears to be extremely likely. The anatomical location and histological structure of the cervix is ideal from the focal infection standpoint. And we may, therefore, well ponder why a focus in one part of the body (tooth, tonsil, gall-bladder, appendix), should be considered a serious menace to health, and yet an active infection of the cervical glands be viewed with indifference and its treatment characterized by neglect. The mere fact that, in the past, treatment of cervical infections has failed to show the spectacular general improvement sometimes noted following removal of other foci, means little. In years past methods of treating cervicitis were characterized by topical applications, and did no more toward the eradication of deep-seated cervical gland infection than did similar treatment in clearing up tonsillar infection. Certainly there is no justification in comparing removal, on the one hand, and topical application, on the other. Yet, such is the situation: the tooth, tonsil, and gall-bladder are freely excised, while the infected cervix, in the vast majority of instances, is subjected to treatment much less effective. I am not advocating random removal of the cervix—far from it; I do urge, however, wider recognition of the cervix as a probable focus of infection and more diligence in its treatment. The acute infection of the cervix is not so much a prob-

lem; it is the chronically-infected, presumably asymptomatic cervix that goes untreated. Few tissues in the body endure chronic infection without, sooner or later, showing local or general manifestation, and the cervix is no exception to this rule.

3. *Local Discomfort.*—As a source of local discomfort, the cervix plays no small rôle. True, patients seldom direct their complaints toward the cervix, but this is readily understandable. Generally speaking, women have only a vague idea as to the location of the cervix and, except during dilatation, the cervix is not particularly sensitive. Its response to trauma and irritation is, therefore, seldom manifest in the form of pain, but rather as more remote pelvic discomfort—interpreted differently by patients and variously described as soreness, bearing-down sensation, tenderness, dyspareunia and aching. Leukorrhea is another local manifestation of cervical origin. Except in acute cervicitis, this is seldom profuse, but like a chronic discharge from the nasal passages it is enough to cause inconvenience and discomfort. How often cervical infections cause dysmenorrhea, backache, urinary symptoms, can only be guessed at, but it is safe to assume that these symptoms do arise on the basis of cervicitis. The secondarily involved parametrial tissues in low grade chronic cervicitis may also account for some of the low backache commonly seen in women.

4. *Sterility.*—With contraception occupying an important place in contemporary social and medical thought, consideration of sterility may seem out of place. Yet to most gynecologists sterility has become an increasingly important problem. Judging from the number of patients who seek advice regarding nonfertility, it would appear that the number of nonproductive marriages is high indeed. This is further emphasized by the great demand for babies for adoption, the demand today being many times greater than the supply. Sterility, then, is a real problem, and one which not infrequently has its origin in some earlier disorder of the uterine cervix. The acutely-infected cervix prohibits upward progress of the sperm, but this phase is recognized and treatment generally instituted. It is the chronically-involved, seemingly innocent cervix that is overlooked even by competent gynecologists.

5. *Dystocia of Cervical Origin.*—The relationship here is seen in the slow or even total lack of dilation even after a long, hard labor. Severe cases due to a badly-scarred cervix are not common, but every obstetrician can recall one or more such examples. Less apparent, but real, is the slow dilatation even in the presence of adequate pains, occasionally seen in young, healthy women due to long-since forgotten cervical infection and its coincident increase in connective tissue. For the same reason, perhaps, cervical tearing is more likely to occur in women who have harbored cervical infection and acquired a liberal increase in connective tissue.

In considering common disorders of the uterine cervix, then, it is wise to think of late complica-

tions. The greatest significance of common cervical disorders lies not so much in their immediate effect but more in their ability to cause remote disease.

TREATMENT

Except for chronic cervicitis, the problem of treating common cervical disorders is no longer difficult. Whereas our predecessors had to choose between surgery and application of some antiseptic, physicians today have quite a wide choice. One reason why we may well be emphatic regarding treatment of cervical disorders is this wide choice and the fact that remedy no longer implies great expense, long hospitalization, and anesthesia. Today most of these disorders can be quickly and satisfactorily cared for by office treatment alone.

In general the only common disorders here discussed calling for surgical treatment are, (1) the occasional, extensively-torn, badly-scarred cervix, and (2), the extensively and chronically infected cervix, particularly in women past thirty-five years of age. Seldom does the simple laceration or the ordinary hypertrophy call for surgical intervention. The badly and chronically infected cervix which fails to respond to office measures is best treated by conization or electrosurgical coning out of gland bearing tissues. In our practice this method has completely supplanted the Sturmdorf operation. It requires but a few days' stay in the hospital, and its performance is many times simpler than the Sturmdorf technique. It must be remembered, however, that such procedure is no substitute for the simpler office measures in the vast majority of cases. Furthermore, stenosis occurs in about 6 per cent to 10 per cent of cases.

For acute cervicitis rest, cleanliness, and avoidance of intracervical manipulation appears to be the only safe treatment. Most cases subside quickly. While chronic cervicitis may respond to local therapy in the form of heat (cautery, coagulation, diathermy, copper ionization, etc.), many cases are stubborn and unresponsive. In women past the active child-bearing age, we have recourse to electrosurgical conization or to surgical procedures but, obviously, such radical steps are seldom warranted in younger women. The vast majority of erosions, eversion, cervical cysts and polyps are successfully treated by simple cautery. The wise choice for treatment for these conditions is indication of their responsiveness as well as effectiveness of methods used.

Certainly, with the remote sequelae of common disorders of the cervix so potentially hazardous, and satisfactory remedial measures so generally available, there is today no good reason why every diseased cervix should not be treated until cured. A diseased cervix is likely to be just as much of a health hazard as a diseased tonsil. Neither should be condoned. Because present-day views seem to indicate a definite relationship between these common cervical disorders and more serious disease usually manifest later in life, the advisability of treating any diseased cervix until cured should be a foregone conclusion.

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WHAT WE MAY EXPECT FROM TREATMENT OF BLADDER TUMORS*

By H. C. BUMPUS, JR., M.D.
Pasadena

DISCUSSION by Robert V. Day, M.D., Los Angeles; Frank Hinman, M.D., San Francisco; A. A. Kutzmann, M.D., Los Angeles.

DURING the past quarter of a century the fact that cancer must be recognized early to be successfully treated has not only been thoroughly appreciated by the profession, but has been the subject of one of the most intensive educational campaigns ever instituted for the instruction of the laity; yet, in as recent a publication as the *Journal of the American Medical Association* for September 12, 1936, we find such an authority as W. Carpenter McCarty stating: "Are we recognizing cancer early? In 1918, I began a series of observations to determine just what effect cancer campaigns were having on the actual sizes of cancers being removed surgically. As pointed out by Balfour, Harrington, and Rankin, only 25 per cent of the cancers of the stomach, 50 per cent of cancers of the breast, and 58 per cent of the cancers of the large intestine are operable when seen by surgeons. These figures have not changed appreciably over a period of fourteen years. There has been little or no change in the average size or percentage of those having glandular involvement in this same period." Unfortunately, cancer of the bladder is no exception to these findings; so we are confronted with the problem of what may be expected from our present methods of treatment in these cases.

MEDICAL LITERATURE OF THE LAST DECADE

During the last decade much has appeared in the medical literature relative to the treatment of tumors of the bladder. Activated by the enthusiasm of Coffey, the possibilities of total cystectomy have been thoroughly expounded, and various techniques for the transplantation of ureters into the bowel developed. In theory such a procedure seems to offer the most probable chance for complete cure. However, in practice these theories, for one reason or another, appear to fall down. If the growth has been discovered early, is it justifiable to resort to these more radical procedures necessitating the transplantation of the ureters and the total removal of the bladder? Few surgeons are willing to subject the patient to these multiple major surgical procedures for the treatment of small tumors, when resection, excision, or some form of thermal destruction offer a possibility of cure almost the equal of radical cystectomy, and with so much less risk to the patient's life.

REVIEW OF LOS ANGELES COUNTY HOSPITAL CASES

Desiring to ascertain, if possible, what these less radical procedures offered in the way of possible

cures, Doctor Silver and I reviewed all cases of tumors of the bladder admitted to the Los Angeles County General Hospital between June, 1927 and June, 1934. The last date was chosen in order that at least eighteen months might elapse following the last treatment in order to more accurately evaluate the final results. There were 135 cases in the group, thirty-six of which were so far advanced that no form of treatment other than cystotomy was undertaken. This was done in eight cases; all died in the hospital. The group of ninety-nine remaining cases seems sufficiently large to suggest what is accomplished by our present methods of treatment in large charity hospitals with constantly changing visiting staffs.

METASTASIS

For instance, in the group studied, metastasis was found at autopsy in 8 per cent of the cases. Spooner, in a review of 167 cases seen at the Mayo Clinic between 1914 and 1931, found that metastasis occurred in forty-nine cases, or 29 per cent. He stated: "Only four of these forty-nine patients presented sufficient clinical symptoms to enable a positive clinical diagnosis of metastasis from tumor to be made." When one reflects that each of these cases was subjected to a most thorough clinical examination prior to surgery, and that in 25 per cent metastasis was discovered at the postmortem examination following their operation, I feel that we may accept these figures as accurate; which indicates that in one of every four cases of tumor of the bladder, metastasis has probably occurred. Therefore, after apparently successful treatment, we should not forget Ewing's observation that "a primary tumor may be at a standstill, while internal metastases are active." If this is borne in mind, the tendency to regard all cases as probable cures living two or three years after surgery will be less, and sufficient time allowed to elapse for these hidden metastases to become demonstrable before any method of treatment is evaluated. In the interim there is no contraindication to cheerfulness regarding the situation if we do not forget, as Keyes has recently stated, that cheerfulness, while the child of hope, is also half-sister to despair.

If this 25 per cent of metastasis is added to the usual mortality associated with ureteral transplantation and cystectomy, the chances of failure with this procedure will be about three to one of possible success.

RADICAL AND LESS RADICAL PROCEDURES

The advocates of less radical procedures, such as resection, stress the fact that if these cases were only seen earlier, greater success would reward their efforts; but, as McCarty has said, they are not being seen earlier as a group. This fact, instead of being ignored, should be accepted in any discussion of treatment of tumors of the bladder. In truth, the early discovery of malignancy has been so dinged into the ears of the laity that they are fast becoming like the villagers that refused to answer a call to a real fire by the small boy that turned in so many false alarms. Propaganda for

* Read before the ninety-fifth semi-annual meeting of the Southern California Medical Association, October 30, 1936, at Los Angeles.

the early discovery of malignancy has been so persistent at times as to almost reach the dimensions of a racket for scaring the laity into the doctors' offices. Let us keep scrupulously to facts, and by honesty retain our self-respect and that of the community. Deceitful propaganda, based on fear, is rapidly defeating its own purpose. We all know that the discovery of malignancy at an early stage does not always insure its successful treatment, as the laity has been led to believe, and as all urologists are aware who have ever attempted to stop the advance of a cancer of the prostate once it has reached dimensions sufficiently large to establish its diagnosis beyond question. Tumors of the bladder are no exception to this rule, that early discovery does not always mean probable cure.

LOCATION OF THE GROWTH

Too often the location of the growth, if it is discovered early, prevents its successful resection. O'Crowley, reporting on the cases recorded in the Carcinoma Registry, gives 10.2 per cent as occurring on the posterior wall and 7.5 per cent in the vault, the only location where comparatively simple resections are feasible and constitute but 18 per cent of the cases. Most bladder tumors, however, are too extensive for such methods of treatment, the vast majority occurring in locations involving the ureters or sphincter. Among the ninety-nine cases in this series from the Los Angeles County General Hospital, resection was done six times, three with transplantation of the ureters. There were four operative deaths, and one patient is living and well over three years after surgery.

MULTIPLE OPERATIONS

The responsibility of recommending these multiple major surgical procedures, including cystectomy, for the eradication of tumors of the bladder makes one hesitate, when as experienced a surgeon as G. G. Smith has recently reported transplanting forty-two ureters in twenty-eight patients with tumors of the bladder, with a mortality of 33 per cent. Certainly the patient, when confronted with such a situation, can hardly be blamed for taking his chances with a less hazardous procedure. Could the surgeon assure the patient that a positive cure would be his reward, even these hazards might seem justified; but the reports of the most ardent advocates of cystectomy do not show that such is the case. Quinby as recently as June, 1935, reports: "Ten patients to date have been treated in the above manner. Two are alive; one, a woman, at three years without evident recurrence; one, a man, at eight years with known recurrence about the rectum and prostate during the past year. Of the remaining eight patients two of the earlier cases died as a direct result of operation, which was imperfect in one way or another. The remaining six patients have died of recurrent cancer at longer or shorter periods after operation."

COMMENT

When such final results are reported from institutions like the Brigham Hospital, where every aid to the successful outcome of any surgical pro-

cedure is available, it seems justifiable for the less fortunately situated not to be stampeded into the undertaking of such major surgical tasks, but to be content with less hazardous methods of treatment. To men such as Quinby, the urologic profession is in the deepest debt for bravely taking advantage of their opportunities, trying out what seems theoretically feasible and then reporting the final results, discouraging as they are. Too frequently one reads of the technique that has been employed and the operative mortality, but is left in the deepest ignorance as regards the final cure of the patient after a period of five years or more.

ON PATHOLOGY OF BLADDER TUMORS

Such omission leaves as erroneous an impression with the reader as the essayists who report long-time results, but fail to state the nature of the malignancy treated. I do not intend to go into a discussion of the pathology of tumors of the bladder, but think it pertinent to state that I am of the belief that tumors of the bladder grow in size, but not in their degree of malignancy with the passage of time. Such being the case, comparatively benign tumors may, due to secondary infection and sloughing, assume the most malignant gross appearance and lead the most conscientious observer to believe he is dealing with a highly malignant condition; when, in fact, he is treating a rather benign tumor, the only malignant potentials of which are those resulting from secondary sepsis, hemorrhage, or urinary obstruction. To illustrate, there were reported by Judd and Phillips four patients suffering from carcinoma of the bladder, but still living and well over twenty years after radical bladder resection. When these operations were performed, Judd considered the growths malignant, yet a recent examination of the tissue showed three of them to be of Grade I or II, and the fourth Grade III. It seems self-evident that if cystectomy is done for tumors of Grade I, the incidence of subsequent recurrence should be nil, and the mortality approximately that of ureteral transplantation for extrophy of the bladder. The greatest scrutiny should, therefore, be exercised to determine in every five years' cure that the original tumor was of a high degree of malignancy, for none can justify such extensive surgical procedures except in the treatment of highly malignant conditions.

Unfortunately, when malignancy of the bladder has developed to a point where less radical means of treatment cannot be used, the possibility of cystectomy has usually passed due to the poor physical condition of the patient, the result of urinary sepsis, secondary anemia, or renal insufficiency. It is this type of patient that is usually encountered in the country's large hospitals.

VALUE OF RADIUM

The results of treating cancer of the cervix with radium made the urologists hopeful that equally gratifying results might follow its use in the bladder. This has not happened even in such splendidly equipped institutions as the Memorial Hospital, brilliant as the results have proved in

certain isolated cases. Barringer reports 39 patients, out of 205 treated, well after a lapse of five years, a 19 per cent incidence. Radium and x-ray were used eight times in our series. Seven of the patients are dead, one is alive and well. The apparent cure in his case has followed the implantation of the radon seeds about a recurrence of the tumor. In such application, radium seems to have its chief usefulness in urologic work. X-ray still remains a palliative measure in tumors of the bladder and, in the experience of the author, is seldom worth the effort or expense it incurs.

CONSIDERATIONS PRELIMINARY TO SURGICAL INTERVENTION

Before undertaking any form of treatment, it is natural for the surgeon to consider cases of malignant diseases in the attitude of "kill or cure." The condition being hopeless unless entirely removed, he naturally feels justified in adapting the most radical of measures. Certainly, this attitude is justified in those cases of malignancy where the possibility of cure is considerably greater than the probability of death associated with the operation. In cases of tumors of the bladder this frequently is not the case, for if we add to the mortality rate associated with ureteral transplantation that of cystectomy, and from the survivors subtract the 25 per cent of undemonstrable metastases, the possibility of cure becomes exceedingly slight; while the reported operative mortality from resection of tumors of the base of the bladder frequently exceeds 25 per cent. To find one out of four patients with tumors of the bladder alive after five years, no matter what the method of treatment used, is unusual.

WHAT TYPE OF PROCEDURE SHOULD BE SELECTED

Are we not then justified in assuming, under certain conditions, that a procedure which will prolong the patient's life is preferable to one that aims only at his cure? Hunt, in reviewing his experience at the Mayo Clinic, writes: "Excepting those lesions amenable to transurethral electrocoagulation, a most conservative estimate places the inoperability of major malignant lesions of the bladder at not less than 25 per cent." During 1926 and 1927, while members of the Mayo Clinic staff, Doctor Hunt and I treated this inoperable group of patients by transvesical destruction with diathermy. The tumors were all Grade III or IV in their degree of malignancy, and each was considered to be inoperable after careful suprapubic exploration. There were twenty-nine cases in the series. In July, 1932, the patients were traced; five were alive without evidence of recurrence all over five years after operation; two others had also lived over five years, approximately 25 per cent of five-year cures. Considering that these were all inoperable cases, the efficacy of this type of treatment seemed to me deserving of more careful consideration and possible wider application in less hopeless cases. Since then Counseller and Braasch have reported seventeen such cases from the Mayo Clinic records, all considered

inoperable but treated by electrocoagulation. Nine of these had malignancy of Grade III or IV, and all had lived over five years following treatment.

In conclusion, they write:

The use of diathermy in the surgical management of carcinoma of the bladder is gradually being extended. It has brought cases in which the condition formerly would have been regarded as inoperable, the growth as non-resectable, within the field of successful treatment. It is our impression that the advantages of diathermy as a transvesical procedure for inoperable or non-resectable lesions of both high and low grades has not been sufficiently recognized.

LOS ANGELES COUNTY HOSPITAL STATISTICS

In the group from the Los Angeles County Hospital, destruction with diathermy was used in seventy-seven of these cases thirty-four times through the urethra, forty-three times by transvesical exposure. Of the former group, eleven are living from three to five years after their transurethral electrocoagulation, a 33 per cent of apparent cures—not a very brilliant result when one considers that thirty of these thirty-four patients had papillary types of tumor presumably of a low degree of malignancy. These figures indicate how uncertain ultimate recovery is, once a diagnosis of tumor of the bladder has been made. Unquestionably, the poor final results were due in no small measure to the failure of these patients to come for a check-up. Crenshaw has shown that, since the establishment of a careful follow-up system among this type of case at the Mayo Clinic, the end-results have improved in direct proportion to the increase in the number of recurrences discovered and destroyed. The latter group of forty-three patients treated transvesically contained twenty-five tumors of papillary type, sixteen of whom are known to be dead and five alive over three years. Of the eighteen infiltrating tumors so treated, ten are known to be dead and but one alive over three years. Fourteen patients, or 35 per cent, died as a result of the operative procedure. Since there are six patients alive from three to five years, and twenty-four known to be dead, there would seem to be approximately a 25 per cent possibility of relief by this method of treatment, which is apparently as high an incident of possible cure as is to be expected by any method of treatment now known. Improvement of results in the future must evidently come from a reduction in the operative mortality in order that 35 per cent of the cases are not immediately eliminated from all possibility of cure. Some have felt that the high mortality was largely due to the involvement of the ureteral orifices in the cautery destruction. In the thirty-four cases treated transurethraly, it was noted that the ureteral orifice had been included in the cautery destruction in thirteen; in only one was convalescence effected. In the transvesical series a ureteral orifice was included twenty-nine times in the cautery destruction, and in ten it was considered a decided factor in an unsatisfactory convalescence if not a direct cause of the patient's death. In the series of twenty-nine inoperable cases referred to earlier, the extensive cautery destruction involved the ureteral office in all the fatal cases, and the re-

sultant inflammatory process extended in several cases along the course of the ureters to the perivesical tissue. Certainly, wherever possible, the insertion of a catheter into an involved ureter and its retention there during the first days of convalescence should be an aid in reducing one cause for the high mortality of transvesical thermal destruction. Apparently such destruction is best accomplished by diathermy; for of eight patients treated with the Percy cautery, four died immediately after operation and two others are known to be dead.

IN CONCLUSION

Surgical diathermy, both transvesical and transurethral, has in this group of seventy-seven patients resulted in seventeen operative deaths and seventeen apparent cures of from three to five years' duration.

We may conclude, then, that surgical diathermy offers a possibility of cure equal to the risk involved in its application. In other forms of treatment the risk of death at, or immediately following operation, appears much greater than the possibility of cure.

112 North Madison Avenue.

DISCUSSION

ROBERT V. DAY, M.D. (1930 Wilshire Boulevard, Los Angeles).—We should feel grateful to Doctor Bumpus for his efforts in the matter of "debunking" misleading propaganda about cancer in general, and bladder carcinoma in particular. Such frank criticism is ordinarily a thankless task, and the critic is all too frequently accused of being a reactionary. But Doctor Bumpus, with his well-known sound clinical judgment and background of experience, is entitled to speak with authority and is virtually immune to any such counter criticism which might be leveled against him. Moreover, Doctor Bumpus sees fit to disagree in most instances with those who advocate such radical procedures as total cystectomy and reimplantation of the ureters. Such measures seldom result in a cure, and in most instances must be accredited to an insufficient experience, wishful thinking or a considerable indifference to the patient's best interests, not to say his exploitation for the sake of performing spectacular operative procedures. The fact that a large percentage of individuals with cancer of the bladder already have metastases not clinically recognizable means, in most instances, that total cystectomy and reimplantation of the ureters (in case the patient survives the operation) was of no avail, and subjected the patient to great danger and needless distress. The absence of metastases can be assured only after the lapse of years or at autopsy.

About twenty years ago Leo Buerger gave us some statistics on bladder tumors which remain just as informative and authoritative as when first published. Analyzing a large series, he stated that 55 per cent were benign papillomas easily cured by electrodesiccation applied through a cystoscope; 37 per cent were papillary carcinomas, most of which were advanced; but a large percentage of these papillary carcinomas could have been cured by electrodesiccation either through a cystoscope or applied through a suprapubic cystotomy opening, had the early warning symptoms been heeded and proper treatment instituted at that time. The remaining 8 per cent are infiltrating tumors. Some of these last are, by reason of their location, susceptible of resection.

The series analyzed by Doctor Bumpus are from all urological services at the county hospital. I am perhaps familiar with a greater percentage of these cases than anyone else, not only because of conducting one of the active services, but also by reason of a certain contact with most of the services as chairman of the urology staff. Most of such cases on admission were far advanced and hopeless

from the standpoint of cure. However, a great deal can be done in the way of palliative procedures by surgical diathermy or, as I have referred to it above, electrodesiccation—meaning the same thing.

Unless implanted cystoscopically in an unopened bladder, radium therapy has proved not only disappointing, but more often than not has been the cause of greatly added distress and suffering. The same applies to therapeutic x-ray, except mild doses for various palliative purposes. After extended experience with the Percy cautery, I find it ill-adapted to the treatment of bladder carcinoma for the reason that the extensive cicatricial tissue ensuing almost always results in ureteral stenoses with grave changes in the kidney following, unless the patient sustains a primary operative death.

The conclusion is, therefore, that practically all of the benign tumors and an overwhelming percentage of the papillary carcinomas could have been cured if an early diagnosis (followed by adequate therapy) had been made. There is usually one or more early symptoms present that should admonish the physician to consult the urologist. The most common, of course, is hematuria or some degree of dysuria. Every patient with hematuria should be subjected to cystoscopic examination unless it is a case of terminal hematuria resulting from a hyperacute posterior urethritis due to gonorrhea. In every case, with the above exception, the patient with hematuria should be cystoscoped at once, not delayed till the bleeding ceases.

One must bear in mind that even those patients with benign papilloma of the bladder, eventually die from carcinoma unless the papilloma is completely destroyed and a cure effected. After the papilloma has been destroyed by electrodesiccation, the patient should return for cystoscopic examination regularly every three or four months for a period of five years. By so doing, any local recurrences will be discovered while still small and, hence, easily destroyed. Even in benign cases local recurrences in the fourth year are not unusual.

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FRANK HINMAN, M.D. (384 Post Street, San Francisco).—Several points of view in this paper merit careful consideration, and it is a privilege to discuss them briefly. First: The early diagnosis of tumors of the bladder has not been advanced. "Deceitful propaganda, based on fear, is rapidly defeating its own purpose. We all know that the discovery of malignancy at an early stage does not always insure its successful treatment." Second: The grade of malignancy of a tumor is constant from beginning to end. "Tumors grow in size, but not in their degree of malignancy with the passage of time." Third: Radium and x-ray are the great disappointments in the treatment of vesical carcinoma. Fourth, as regards surgery: Tumors, even when discovered early, will be located in a position which would permit resection in less than 20 per cent. Even in these cases the results of surgery are poor. The mortality of uretero-intestinal implantation and cystectomy is high (cited: 33 per cent, G. G. Smith; 20 per cent, Quinby) and the chance of cure is so small (cited: 10 per cent, Quinby) as to impeach the operation.

Let us examine the conviction of mind implied in these four assertions, and the conclusion that diathermy is the one method of choice for the treatment of all tumors.

From the surgeon's point of view, an early diagnosis is one which antedates extension locally and the onset of metastases. It has no reference to duration. There certainly can be no objection to an early diagnosis in this sense, and the results should be analyzed and compared accordingly. The fact that an increase in the number of early diagnoses has not been made is no argument against the advantages of such a diagnosis. As to the citation of Quinby's discouraging results with surgery, apparently only one of his patients had an early diagnosis. In Bumpus' own series, 36 of 135 patients had cancer so far advanced, on the patient's admission to the county hospital, that any form of treatment was hopeless. Twenty-five others had metastases, which put them into the same class. How many of the remaining patients had an early diagnosis is not stated. It is probable that a diagnosis had been made in the majority and that many had been given some form of treatment before their admission. This is a cause of real discouragement to surgeons. If the diagnosis

is early, the decision to operate should be made in the few weeks after the discovery of the tumor and not put off until years later. Then it is too late, because, no matter how well the local appearance has been kept in check by repeated fulgurations, the growth probably has extended locally and spread elsewhere. The difficulty in making this decision is serious and distressing, and is bound up with our ideas of the variability in the malignancy of these tumors.

From the standpoint of treatment, tumors of the bladder are of two kinds—benign and malignant—and all benign papillomata are potentially malignant and recurrent. Twenty-five years ago Beer introduced the use of fulguration, and the perfection of this method has revolutionized the treatment of tumors of the bladder. With regular follow-up for recurrences and implantations, fulguration (diathermy) undoubtedly cures benign and malignant papillomata. To advocate surgery in these cases would be criminal. Frequently the clinical differentiation between malignant papilloma and papillary carcinoma (infiltrating) is impossible, and biopsy reports are often unreliable. A trial of fulguration in such an instance is proper. No doubt many early types of papillary carcinoma are cured by diathermy. Indecision and doubt arise when the response is slow and recurrence regular; this is the time to consult with the patient and to decide for or against surgery. The delay, which in many cases, unfortunately, has been justified, too often has made this a late, instead of an early diagnosis, as it was when the tumor was first discovered. With other tumors frankly malignant and infiltrating on first study, a test period of diathermy, provided surgery is contemplated, is not indicated. The important question, once the malignancy is established pathologically, is: has it spread from its primary location to adjacent structures, to lymph nodes, to bones, or elsewhere? If a careful study gives a negative answer, surgery is indicated. In my experience, the grading of tumors after Broders gives no advantage in answering the foregoing questions, except in the case of papillary carcinoma in which a grading of three or four might hasten a decision in favor of surgery. A low grade of malignancy in squamous-cell carcinoma, on the other hand, is no argument against surgery.

Many still adhere to the use of radium and x-ray therapy. My experience with radiotherapy corresponds to that of Doctor Bumpus'. However, many tumors not curable by radiation are radiosensitive and irradiation preliminary to resection seems logical, particularly if the difficulties of technique are considered as the principal cause for the poor results. The need of radiation before cystectomy is not similar.

The clean resection of a vesical cancer, usually vascular, friable and much more extensive than judged cystoscopically, is extremely difficult—much more so than total cystectomy. The removal of such a tumor with a wide margin of healthy wall without spreading tumor cells all over the operative field or squeezing them into lymph and blood vessels is not easy, particularly when the tumor is posterior and near the ureteral orifice or trigone, as the majority of them are. Beer has emphasized the advantages, when making resections, of using the electric cautery and cautery knife, and of flushing the whole field with alcohol afterward. Even with these precautions the chance of a complete clean removal is small. Preliminary radiation, perhaps by attenuating the growth and thereby diminishing the risk of implantation at the time of surgery, may increase the likelihood of cure. When one considers, in connection with these technical difficulties, the small proportion of cases in which the position of the tumor (20 per cent) and an early diagnosis (uncertain) give an indication for resection, it is no wonder that the few successes are lost in the mass of failures. The decision to resect a tumor of the bladder, therefore, should be based on the most rigid indications, and all the refinements of technique should be followed most conscientiously. Even then cures will be fewer than with total cystectomy in comparable cases because removal of the bladder unopened and intact removes the great risk of implantation. It is for this reason that total cystectomy is a better surgical procedure and one which would replace resection completely were it not for the limitations imposed by the necessity of diversion of the urine. The cures in a series

of patients operated upon at the period of early diagnosis (growth limited to the bladder) who survive ureteral transplantation and cystectomy should be near 100 per cent and not the one cure in ten of Quinby's series, held up by the author as an impeachment of the operation. To my mind, Quinby showed poor judgment in the selection of his test material, and his results in ten patients—in seven of whom at least the growth had spread beyond the bladder—form no argument against performing cystectomy for patients in whom the growth is limited to the bladder. Doctor Bumpus cites a mortality of 35 per cent for so-called surgical diathermy, which is considerably higher than Quinby's 20 per cent for cystectomy. This risk, therefore, cannot be prohibitive, since he takes a greater risk with less promise of cure.

In conclusion, I would say that all of these methods have a place in our attack on cancer of the bladder. Fulguration (diathermy) undoubtedly is the most useful. X-ray and radium may be useful at times. Resection has definite limitations. Ureteral transplantation and cystectomy should be done for patients with an early diagnosis and not left as a measure of last resort, as it has been. Ureteral transplantation and surgical diathermy should be resorted to occasionally when clean cystectomy is found to be impossible. Previous diversion of the urine will reduce materially the high mortality which is caused principally by ureteral obstruction and infection; much more radical electrocoagulation is permitted because there is no fear of ureteral obstruction and the bladder is no longer needed.

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A. A. KUTZMANN, M.D. (1930 Wilshire Boulevard, Los Angeles).—Doctor Bumpus' paper is so comprehensive that one cannot add anything, merely further emphasize some of the important points. The treatment of tumors of the bladder has always been a bugbear to the urologist. In so many of the cases he seems almost defeated in his endeavors before he even begins. This may be considered as due to several facts. First, the insidiousness of the onset of this disease. Too often bladder tumors are silent until developed far along, before the first danger signal is detected, probably an hematuria, or some other less significant disturbance in urination. Secondly, the lack of proper recognition of signs and symptoms by the general practitioner. Too often the physician and patient are lulled into a false sense of security because an hematuria was present on only several voidings, or for one day and disappeared spontaneously, only to reappear later when the case is beyond help. Let me make a plea here for the immediate proper investigation of any hematuria, no matter how apparently insignificant. Statistics have shown that almost one-half of all hematurias are due to some type of new growth in the urinary tract. This sign may well be classified with the early detection of a lump in the breast. The physician and patient should never be satisfied until a proper explanation for the hematuria has been found. It can be seen, therefore, that the first and second factors prevent the probability of an early recognition, which is so paramount. This, however, accounts for only a part of the cases, since in many others, as has already been pointed out, signs and symptoms appear for the first time only after the growth has become far advanced.

Third, all tumors of the bladder are potentially or definitely malignant. This is a hard fact driven home repeatedly to all individuals who have had experience with these growths. Even an occasional growth, benign under the microscope, will recur at times leading to the clinical course of a mildly malignant growth. While it does not always seem so, I have been forced to the conclusion in some cases that, as the course of bladder tumors advances, especially while being treated, the degree of malignancy seems to increase. This I have believed to be due to a stimulation and irritation of the urinary infection and treatment; especially with the latter it has appeared that insufficient fulguration through the cystoscope or the action of radium seemed to occasionally flare up some of the carcinomata to a more rapid growth and a more extensive infiltration. Fourth, most bladder tumors are usually situated about the vital portions of the bladder—the trigone, ureteral orifices, and vesical neck. Since the bladder is an organ upon whose good function depends the well-being

of other organs, there results the encountering of many technical difficulties from these structures, especially in the surgical treatment of bladder tumors, such as resection with ureteral reimplantation, ureteral transplantation, cystectomy, etc. These, under our present state of development, still carry a very appreciative mortality.

I heartily agree with Doctor Bumpus that the diathermic destruction of bladder growths, especially the large ones, should receive more consideration. It is true that the basic principles in cancer surgery call for the complete dissection of the growth with its draining lymphatics, but this is not always practical in bladder surgery. The technical operative difficulties seem to impose too great a burden on the patient, leading to high mortality. It is beautiful, spectacular surgery for the surgeon, but does not necessarily help the patient. Even if the patient survives this increased surgical risk, morbidity still shows, regardless of the type of treatment, that only 20 to 25 per cent of patients are alive after the usual three- to five-year cure period. Too often these patients are seen late, either because of failure to recognize early signs or the long, insidious course of the disease; there have occurred permanent destructive changes due to infection, obstruction, ureteral dilatation and renal damage, resulting in additional risk for any type procedure. The use of diathermy under complete vision through an open cystotomy, especially in cases giving an almost hopeless prognosis, has made it possible to completely destroy an appreciable number of these growths, especially when extensive, and to finally end up with as many cases benefited as with the other more formidable procedures. The writer has known of a patient to be well after ten years following the diathermic destruction of a Grade 4 growth through a cystotomy.

ENTERITIS OF UNKNOWN ORIGIN*

REPORT OF AN EPIDEMIC IN A CHILDREN'S
INSTITUTION: 27 CASES WITH 6 DEATHS

By J. C. GEIGER, M.D.
San Francisco

BETWEEN February and August, 1936, an outbreak of enteritis occurred in an institution for young babies. The institution is a home for infants, and the physical plant consists of three attractive, well-built, well-planned cottages. The facilities available for the care of infants are excellent, and the four different wards and three other smaller rooms permit of adequate isolation for individual babies or small groups of infants.

FIRST REPORTS

It would seem appropriate to invite attention to certain circumstances involved in the recent incident to be described, and the part played by the Department of Public Health. Babies, to the number of at least 27 were affected, and 6 of these died, during the period of February to August, 1936. The 6 deaths occurred April 10, April 12, May 10, June 4, August 1, and August 10, and the causes of death given included enteritis (unqualified, and as one of two or more causes), and others, as otitis media, mastoiditis, congenital cyst of the cerebrum, and bronchopneumonia. The Department was uninformed, however, of any other instances by the attending physicians or by the other physicians whose advice was sought in consultation or discussion. On routine inspection of the home, for renewal of permit, and following an anonymous inquiry as to "whether everything is all right in

that institution," it was learned that there had been 27 cases and 6 deaths of an affection that had presented definite diagnostic difficulties as well as a definite epidemiologic problem. It is very regrettable that the incident was not reported to the Department of Public Health, for the study that it was possible to make was entirely in retrospect, and reporting of the incident would have permitted a concurrent epidemiologic study which might have been more fruitful.

PREVENTIVE MEASURES

As immediate measures instituted in August, against further cases, no admissions were permitted to the institution, and discharges were to be made only after complete recovery of the child and freedom from all clinical signs of the affection. This limited the incidence to the occupants of the home. For the succeeding period of about four weeks no new cases developed, and the outbreak completely subsided. Laboratory studies of specimens from members of the staff and personnel failed to reveal the carrier state for any of the organisms related to the enteric fevers. Since certain epidemiologic points of interest had not been secured, the study was undertaken in an attempt to compile relevant information from all available sources.

IMPRESSIONS

From the accumulated data, the following impressions are formulated:

1. In both cases and deaths, distribution was equal between males and females.
2. The mean age (on admission), among those affected approximates 30 days, the median being 20 days; in the deaths, however, ages on admission to the institution were 9, 5, 49, 45, 127, and 101 days, respectively.
3. The date of onset in the first cases recorded was February 25 (in cases 1 and 2), 4 and 5 days after admission, respectively.
4. Additional instances occurred for slightly more than five months to the total number of 27, at intervals (between dates of onset of successive cases), of from 7 to 21 days.
5. The time intervals between date of admission and date of onset in individual cases, as nearly as can be ascertained from the record, varied from 1 to 33 days. The longest intervals were 19, 24, and 33, and the shortest was one day. These, possibly even the two and three days' periods also, should be discarded before attempting to determine a mean for the series. It would appear that the normal period between admission and onset dates were seven days, although a variation of four days above or below this mean should be allowed.
6. From the case records alone, it is impossible to formulate accurate impressions of the severity of the diarrhoea. Vomiting, while it did occur, was not always present. In evaluating diarrhoea, one is confronted with meager information from the case records also. An arbitrary definition of a definite change in the number of stools with description of "curdy," "loose," or "watery," and four to five or more stools daily without qualifying

* From the office of the Director, Department of Public Health, City and County of San Francisco.

description, was set up by the Department of Health.

7. Nervous system involvement, *per se*, was not described on the case record. In a supplementary tabulation eye signs, restlessness, opisthotonus, paralysis, paresis, and spasticity of extremities were recorded by the institution's physician.

8. Laboratory study of blood, stool, and cerebrospinal fluid were unproductive of significant findings.

9. In the supplementary tabulation by the institution's physician, other physical signs are recorded, as "cold extremities," "mottled skin," "cyanosis," which might be interpreted as neuro-circulatory changes, but these are not recorded on the case records.

10. Abdominal distension, congested mucous membrane of the throat, loss of weight, dehydration, edema, were all mentioned in the supplementary report of the institution's physician, also; but, again, these are not included in the regular case record.

11. Autopsy findings present no apparent consistent and uniform changes. Definite meningitic reactions were recorded in two instances. Hemorrhagic necrosis of the lining of the lateral ventricles with clumps of blood pigment in the spleen and early pneumonia appeared in two other cases. Otitis media and mastoiditis occurred in one instance. In the first death no definite pathology was noted, and in only two other instances were there any significant changes in the gastro-intestinal tract; in one, a thrombosis of the epiploic veins with points of hyperemia in the wall of the stomach; and in one, mild enteritis without ulceration was recorded.

12. The duration of the illness varied from six to twenty-eight days.

13. The case fatality rate of the series studied, six deaths in twenty-seven cases, is 22 per cent.

SUMMARY

When the Department of Health first learned of the incident which is the basis for this study, about the middle of August, approximately six months after the probable original cases, and the whole subject was discussed with the officials of the institution, it was evident that the affection was a diagnostic problem. From the data available and used in this study, also, there is still a diagnostic problem. The epidemiology, likewise, is obscure. There was some suspicion at the first that the cases were due to a virus, or caused by an atypical form of dysentery with neurologic manifestations. There is no evidence, however, at this time to support either theoretical possibility, except the absence of positive bacteriologic and pathologic data.

One is impressed that the whole series of cases originated in the one or two children admitted in February, apparently with an affection manifesting itself primarily in a diarrhoea, the resulting infection-chain continuing for over five months, involving at least 27 infants, with six fatalities, through some channel not closed by the isolation techniques at first practiced.

101 Grove Street.

ACUTE ANTERIOR POLIOMYELITIS: GYNECOLOGIC SYMPTOMS*

By DWIGHT D. YOUNG, M.D.
Los Angeles

DISCUSSION by Donald G. Tollefson, M.D., Los Angeles; Margaret Schulze, M.D., San Francisco; L. A. Emge, M.D., San Francisco.

IN the recent epidemic of acute anterior poliomyelitis in Los Angeles, during the spring of 1934, and 1935, many unusual symptoms and physical findings were observed. In investigating records of previous epidemics, these unusual features were not recorded and probably did not occur. Among the female patients the prevalence of menstrual dysfunctions, typically appearing at the first menstrual period after the onset of the disease, has led to a more thorough investigation of this particular phase.

It is not our purpose, in presenting this paper, to discuss the epidemiology, symptomatology, or clinical aspects of poliomyelitis. It is important, however, to consider briefly a few of the characteristic features of the Los Angeles epidemic, to enable us to obtain a better understanding of the gynecologic problems presented.

SPECIAL FEATURES IN THE LOS ANGELES OUTBREAK

As you will recall, poliomyelitis, in its typical form, occurs in two distinct types, namely, bulbar and spinal. It is the spinal type with which we are primarily concerned. In the spinal type the motor cells in the anterior horn of the spinal cord are involved, producing a motor paralysis of the skeletal muscles. The paralyzes are of the flaccid type, resulting in muscular atrophy from disuse. This usually results in a partial or a total paralysis of the muscle groups affected, which may be temporary or permanent, depending upon the severity of the process. In an article, entitled "Poliomyelitis—The Los Angeles Epidemic of 1934," by Meals, Hauser, and Bower, which appeared in two issues of CALIFORNIA AND WESTERN MEDICINE, August and September, 1935, the authors call particular attention to the atypical paralyzes characterizing this epidemic. "The objective findings," they state, "were as atypical as the subjective symptoms. Muscle weakness was often very mild or transient, but pain on motion was sometimes pronounced. Frequently, muscle checks showed no weakness nor asymmetry, sometimes no pain, but a marked fatigability of the affected extremity on repeated tests. Involvement of sensory as well as motor areas of the central nervous system was demonstrated both pathologically and clinically. Symptoms were present in some cases which indicated involvement of the sympathetic nervous system. Recovery has apparently been complete in 80 per cent of patients, some of whom had been severely paralyzed. Sequelae included symptoms of psychogenic and sympathetic nervous system origin."

* Read before the Obstetrics and Gynecology Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25-28, 1936.

In a paper presented to the Mayo Clinic staff meeting in July, 1934, Rosenow, Heilman, and Pettet referred to this epidemic as polio-encephalitis. Other investigators have called attention to the apparent combination of symptoms and signs resembling encephalitis as well as poliomyelitis, producing a preponderance of neurogenic and psychogenic symptoms. Attention has also been directed to the apparent involvement of the sympathetic and the parasympathetic nerve roots, both sensory and motor. The typical involvement of the anterior horn cells, as previously seen in poliomyelitis, while present in a few instances, has been fleeting in character, producing transitory paralyses for the most part, and entirely absent in the majority of cases. Because of the atypical nature of this epidemic, Aycock of Boston has suggested that it be designated as "Los Angeles Disease X."

ATYPICAL NATURE OF THE LOS ANGELES OUTBREAK

The clinicians in Los Angeles, who have had these patients under their observation, agree that if this disease is to be called poliomyelitis, it must be recognized as an atypical manifestation of the process. It does not conform to the previous symptomatology or clinical findings generally associated with typical poliomyelitis. We present these observations since we feel that they have an important bearing on our present problem, especially since menstrual irregularities have characterized this disease in the female patient, but have not been reported in any previous epidemics of typical poliomyelitis. To prevent confusion, however, we will continue to refer to the disease as poliomyelitis in our discussion.

MENSTRUAL DYSFUNCTION FEATURES

This brings us to our consideration of the gynecologic problems in this epidemic. The manifestations of menstrual dysfunction have not only been present in the early, acute stages of poliomyelitis, but, for the greater majority, they have continued through the prolonged stages of the convalescent period.

Some 112 patients, employees of the Los Angeles County General Hospital, were interviewed and studied in an attempt to obtain a more accurate picture of the various types of menstrual disorders encountered. This group is composed of doctors, nurses, social service workers, laboratory technicians, and hospital attendants, who contracted the disease during the epidemics of 1934 and 1935. They were all admitted to the contagious unit of the General Hospital for the usual isolation period. They are still under observation and are receiving treatment, although many of them have been able to return to full or part-time duty.

PRESENT WORKING STATUS OF ONE HUNDRED AND TWELVE PATIENTS

It is of interest to analyze the present working status of this group of patients. We will present these statistics in a little more detail than may seem necessary, since we have been convinced, as

TABLE 1.—Analysis of 112 Patients as to Present Status

112 Patients— Both Epidemics (1934 and 1935)	
70 patients in the 1934 epidemic group.	
42 patients in the 1935 epidemic group.	
58 patients now in hospitals or rest homes (both groups).	
54 patients ambulatory—attending clinics (both groups).	

a result of this survey, that the disturbances in menstruation have played an important rôle in the prolonged convalescent periods and for the consequent loss of working time.

There are seventy patients who contracted the disease in 1934, and forty-two patients who belong in the 1935 epidemic group. These figures confirm the observation that the 1934 epidemic was by far the more extensive of the two. Of the 112 patients studied, fifty-eight are still confined in the various hospitals and rest homes, as shown in Table 1. This figure represents 51 per cent of the total number of patients in both the 1934 and 1935 epidemic groups included in this survey. Ambulatory are fifty-four patients, now attending the various follow-up clinics.

In Table 2 the following facts may be noted. In the 1934 group, thirty-five patients are still hospitalized and thirty-five are attending the clinics. Of the thirty-five patients now hospitalized, twenty-five have been off duty since the onset of the illness for an average of eighteen months each. Ten of this group have tried to return to duty, working at short intervals, for a total average of about four months each. All in this group of ten have had relapses and are now off duty. Of the thirty-five patients who are ambulatory and attending clinics, eleven have not returned to duty since the onset of the disease in the spring of 1934; twenty-four patients in the ambulatory group are now on full or part-time duty, but the total average working time has been less than five months each over a period of eighteen months.

In Table 3 we recapitulate the seventy patients representing the 1934 epidemic in our survey, including both the hospital and clinic groups. This reveals the rather startling fact that forty-six patients are still off duty one and one-half years after the onset of the disease, and that thirty-six have been off duty for the entire period of eighteen months. Only twenty-four of this group are now on duty; ten have been able to work a few months each, but are not working at present.

TABLE 2.—Working Status of 1934 Group

Analysis of the 1934 Group of Seventy Patients	
35 now in hospitals or rest homes.	
25 off duty since onset—average eighteen months.	
10 off duty at present. Have worked at intervals for a total average of four months each.	
35 ambulatory. Attending clinics.	
11 off duty since onset—average eighteen months.	
24 on duty at present. Average working time, five months each.	

TABLE 3.—Recapitulation of the 1934 Group—Working Status

Recapitulation of the 1934 Group
46 off duty at present.
36 off duty since onset—average eighteen months.
10 off duty at present. Have worked at intervals for total average of four months each.
24 on duty at present. Have averaged a total of five months' working time each in past eighteen months.

The thirty-four patients who have worked or who are working now, have only averaged a total of five working months during the past eighteen months. It is quite apparent from these statistics that, in addition to the medical problems presented, we are also confronted with an important economic problem, since all of these patients have been or are now drawing compensation.

A similar analysis of the forty-two patients from the 1935 epidemic, as shown in Table 4, reveals the fact that twenty-three are still hospitalized and that nineteen are attending clinics. In the hospital group, only three have been able to return to duty, working an average of one to two months each. Relapses have occurred, and they are now off duty. In the clinic group of nineteen, three patients are still off duty, while sixteen of this group are now working an average of less than two months each.

In Table 5 a recapitulation of the 1935 epidemic, including both the hospital and clinic groups, gives the following information: Twenty-six are off duty at present; twenty-three have been off duty since the onset of the disease for an average of eight months each; three have made an attempt to work, but are off duty now, having averaged less than two months working time each. There are sixteen in this group who are working at present, but have averaged less than two months each.

COMPARISON BETWEEN THE 1934 AND 1935 OUTBREAKS

As a result of this comparative analysis, we were immediately impressed with the fact that the relative time off duty is much greater in the 1934 than in the 1935 epidemic. The latter group has returned to duty much earlier and has lost far less working time. This finding may be explained on two possible bases:

1. It is generally conceded that the 1935 epidemic was less severe than the 1934.
2. On the basis of previous experiences with the sequence of events in the 1934 group, recur-

TABLE 4.—Working Status of 1935 Group

Analysis of 1935 Group of Forty-two Patients
23 now in hospitals or rest homes.
20 off duty since onset—average eight months.
3 off duty at present. Have worked at intervals for total average of two months each.
19 ambulatory—attending clinics.
3 off duty since onset—average eight months.
16 on duty at present. Average working time two months each.

TABLE 5.—Recapitulation of the Working Status of 1935 Group

Recapitulation of the 1935 Group
26 off duty at present.
23 off duty since onset—average eight months.
3 off duty at present. Have worked at intervals for total average of two months each.
16 on duty at present. Average working time two months each.

rences or relapses may yet occur which will necessitate an additional loss of working time.

It is to be sincerely hoped that this does not prove to be true.

AGE INCIDENCE

In the article by Meals, Hauser, and Bower, previously referred to, the authors call attention to another interesting feature of the Los Angeles epidemic, namely, the increased incidence among young adults as well as an increase in the later decades. The age incidence of our group would seem to corroborate this observation. The youngest patient in our series was eighteen years of age at the onset of the disease; the oldest, forty-nine.

Listing the 112 patients by five-year age groups, the following information is obtained, as illustrated in Table 6:

There were six patients below the age of 20 at the onset of the disease.

Fifty-two patients between the ages of 20 and 25.

Twenty-five patients between the ages of 25 and 30.

Thirteen patients between 30 and 35.

Six patients from 30 to 40, and ten patients above the age of 40.

In other words, 74 per cent of the patients in our series were below thirty years of age. The greatest incidence was between the ages of 18 and 25, representing a total of fifty-eight patients, or 52 per cent of the entire group. These figures are of major importance to us in analyzing menstrual irregularities, since the heaviest age incidence of the disease coincides with the most active period of sexual life.

It is known, from previous epidemics, that poliomyelitis has always been primarily a disease of children and young adults, rarely involving adults beyond their early twenties. In our series, twenty-nine patients were over thirty years of age at the time of onset of the disease. This is another one of the rather unusual features of the

TABLE 6.—Age Incidence by Five-Year Groups

Age Incidence at Onset of Disease—By Five-Year Age Groups	
Age Group	Number of Patients
Below 20	6
20-25	52
25-30	25
30-35	13
35-40	6
Above 40	10
	112
Below 30—74%	
Above 30—26%	
	Heaviest incidence 18-25—52%

TABLE 7.—*Analysis of Cases to Be Presented for Disturbances in Menstruation*

112 cases presented in the survey.
4 cases discarded.
2 previous hysterectomy.
2 menopause prior to poliomyelitis.
108 cases to be analyzed.

Los Angeles epidemic. In our survey, however, it must be remembered that we are dealing with hospital employees. It is to be expected that the heaviest incidence would be between the ages of 18 and 25, since the largest occupational group is represented by student nurses. We could not expect to have patients younger than eighteen, since this age represents the minimum requirements for entering student training.

PATIENTS INCLUDED IN THIS STUDY

We wish to emphasize at this point in our discussion that our survey includes 112 consecutive patients seen by us in the various hospitals and clinics wherein they are now being treated. These cases have not been selected at random for the sake of statistics. This statement will be self-evident, as we individualize the various types of response to the disease from the standpoint of the presence or absence of disorders in menstruation.

In recording the menstrual histories of these patients, four of the group of 112 could not be included; two have had hysterectomies performed several years prior to the onset of poliomyelitis. The remaining two had not menstruated for from three to five years before the onset of the disease, having been definitely in the menopause a sufficiently long interval before the onset to experience no subjective changes. There remain 108 cases to be presented for our analysis of menstrual irregularities.

DYSMENORRHEA

Dysmenorrhea has proved to be the most distressing symptom in the syndrome, as well as the one most constantly present. In the following discussion, unless attention is especially directed to the menstrual history before the onset of poliomyelitis, it is to be understood that menstruation was essentially normal; ninety-two, or 85 per cent of the 108 patients, having reported dysmenorrhea as being the most prominent gynecologic complaint following poliomyelitis. Obviously, this one symptom occupies a position of major prominence

TABLE 8.—*Types of Menstrual Changes Following Poliomyelitis*

92—Dysmenorrhea following poliomyelitis (85 per cent).
7—No change in menstruation.
2—No dysmenorrhea. Poliomyelitis prodromal symptoms with onset of every menstrual period.
5—No dysmenorrhea—decreased menstrual flow.
1—No dysmenorrhea—menstrual cycle shortened.
1—Dysmenorrhea disappeared after poliomyelitis.
108 cases analyzed.

in enumerating the gynecologic sequelae of poliomyelitis.

Two patients reported no dysmenorrhea, but complained of very severe poliomyelitis prodromal symptoms, beginning about a week before the onset of each menstrual period and continuing through the entire menstrual phase. The symptoms complained of are severe headaches, aching in the arms and legs, nausea, vomiting, general malaise, anorexia—in brief, the typical symptom complex which characterized the prodromal stages of poliomyelitis. The symptoms are of such a severe nature that bed rest is required for two to three days of every month.

Five patients reported no dysmenorrhea, but noted a marked decrease in menstrual flow; three of the five had a six months' period of amenorrhea immediately following the onset of poliomyelitis. After this period of amenorrhea, menstruation was reestablished, but it has been of the totally irregular, unpredictable type, associated with a marked decrease in the number of days of menstrual flow and a decrease in the daily blood loss.

The remaining two of the five patients reporting decreased menstruation noted a marked decrease in the number of days of menstruation. The average flow of five days before the onset of poliomyelitis was decreased to two days following the disease. There has been an accompanying decrease in the daily menstrual volume. With one the interval remained the same, twenty-eight days, while the other illustrates the long-interval type of irregularity, prolonged to forty days from the previously normal twenty-eight-day cycle.

An increase in menstrual flow, following poliomyelitis, is reported by one patient. The cycle has been changed from the normal, 28 x 4-day type, to 21 x 7 days, with a marked increase in daily blood volume. No dysmenorrhea accompanied this change. The last patient shown in Table 8, presenting a cure of dysmenorrhea following poliomyelitis, has an interesting history, which will be briefly outlined. Prior to the onset of the disease, this patient had an irregular menstrual cycle, of the long-interval type, averaging thirty-five to forty-five days. The daily menstrual flow was very heavy, at times amounting to a hemorrhage. The flow was never less than fourteen days' duration. Severe dysmenorrhea occurred with every menstrual period, seven days premenstrual and lasting through the entire menstrual phase of fourteen days. Beginning with the first menstruation after the onset of poliomyelitis, the dysmenorrhea disappeared entirely and the menstrual cycle became regular, 30 x 4 days, with a normal daily flow.

GROUP CLASSIFICATIONS

It would be impossible to present the histories of 108 patients in detail. We have made an attempt to classify them as accurately as possible in a few characteristic groups. In eliciting symptoms, particularly the symptom of pain, we are all familiar with the difficulties encountered in evaluating its severity or intensity. After a careful analysis of these symptoms, we feel that we can

TABLE 9.—Severity of Dysmenorrhea Following Poliomyelitis

14 mild.
14 moderately severe.
14 severe.
50 very severe.
92 patients with dysmenorrhea following poliomyelitis.

present a fairly accurate picture of the severity of the dysmenorrheas. Accordingly, an arbitrary classification has been made of mild, moderately severe, severe, and very severe, in an attempt to qualify the degree of pain elicited in our histories.

Table 9 illustrates this classification. We also note in the above analysis that fifty of the ninety-two patients reporting dysmenorrhea after poliomyelitis have complained of the very severe type of pain.

In a more detailed analysis of the group of ninety-two patients complaining of dysmenorrhea after poliomyelitis, we discover the very interesting fact that fifty-two had never had this symptom before the onset of the disease. In other words, 57 per cent of this group, presenting dysmenorrhea as the prominent symptom following poliomyelitis, had not previously experienced painful menstruation. Forty patients of this group did have dysmenorrhea before the onset of the disease, but the majority complained of a sharp increase in the intensity of pain following the illness. This group will be analyzed later on in our discussion. In a compilation of symptoms, as given by the group of fifty-two patients who had not had the symptom of dysmenorrhea before the onset of poliomyelitis, the following information is obtained, as illustrated in Table 11:

Twenty-four patients of this group gave dysmenorrhea as the only menstrual symptom. Ten patients reported very severe dysmenorrhea associated with a marked decrease in menstrual flow. (Alterations in the interval, duration, and character of the flow are listed separately in Table 11.)

Nine patients reported very severe dysmenorrhea associated with a profuse menstrual flow.

Three patients have very severe dysmenorrhea every third period.

Three patients have totally irregular menstruation of the unpredictable type, also associated with the very severe type of painful menstruation.

REPORT OF CASES

The three case histories to be presented are as follows:

CASE 1.—Student nurse, age 22. Onset of poliomyelitis, June, 1935. Menstrual history before poliomyelitis: regu-

TABLE 10.—Illustrating Number of Patients With or Without Dysmenorrhea Before the Onset of Poliomyelitis

52 patients had no dysmenorrhea before poliomyelitis (57 per cent).
40 patients had dysmenorrhea before poliomyelitis (43 per cent).
92

TABLE 11.—Analysis of Symptoms in Group Without Dysmenorrhea Before Poliomyelitis

Decrease in flow	24—Dysmenorrhea as the only menstrual symptom.
	4—Very severe dysmenorrhea; same interval; marked decrease in daily blood volume.
	4—Very severe dysmenorrhea; irregular interval (long) increased days of flow; decreased daily blood volume.
	2—Very severe dysmenorrhea; same interval; decreased days of flow; decreased daily blood volume.
Increase in flow	5—Very severe dysmenorrhea; irregular interval (shortened); increased days of flow; profuse daily blood volume.
	4—Very severe dysmenorrhea; same interval same number of days of flow; profuse daily blood volume.
	3—Very severe dysmenorrhea every third menstrual period.
	3—Very severe dysmenorrhea. Totally irregular interval.
	3—Case histories to be presented briefly.
	52

lar, 28 x 7-day type, profuse daily flow. On three occasions she had a sharp hemorrhage, beginning with the menstrual flow. In January, 1934, eighteen months before the onset of poliomyelitis, she flowed steadily for two and one-half months, requiring a blood transfusion, dilatation, curettage, and injections of Antituitrin S. This treatment successfully stopped the hemorrhage, but the profuse menstrual periods continued up to the onset of poliomyelitis. There was no dysmenorrhea associated with the abnormal menstruation. After the onset of poliomyelitis, the interval remained the same—twenty-eight days; but the duration has been decreased to two days, with a very scant daily blood volume. There has been very severe dysmenorrhea, beginning the first period after the onset of the disease, both premenstrual and menstrual.

CASE 2.—Student nurse, age 20. Onset of poliomyelitis, June, 1935. Menstrual history before poliomyelitis: regular, 28 x 4-day type, with average daily flow. No dysmenorrhea.

After poliomyelitis: For the first three months, very severe dysmenorrhea, with irregular menstruation (short interval type), 14 x 7 days, with excessive daily blood loss. Following this three months' interval, there was a period of amenorrhea, which has persisted up to the present time.

CASE 3.—Student nurse, age 20. Onset of poliomyelitis, June, 1934. Previous menstrual history: regular, 28 x 5-day type, average daily flow. No dysmenorrhea.

After poliomyelitis: First three months, very severe dysmenorrhea, associated with excessive daily blood loss, although the interval and duration remained the same.

The following three months there was a period of amenorrhea.

Menstruation was reestablished after three months, but it has been totally irregular, with very severe dysmenorrhea ever since.

COMMENT

We cannot present each history in detail. Let it suffice to say that the average history elicited from this group presented perfectly normal menstruation before the onset of poliomyelitis; but after the disease the typical story is primarily of dysmenorrhea, beginning from two to seven days before menstruation and continuing into the menstrual phase of the cycle for a period of two to seven days. The other irregularities in menstruation have been briefly outlined.

TABLE 12.—*Severity of Dysmenorrhea Before Poliomyelitis*

21—Mild (52 per cent).
6—Moderately severe.
9—Severe.
4—Very severe.
40 patients complaining of dysmenorrhea prior to poliomyelitis.

There are three patients in this group, still on absolute bed rest, who experience only a few days each month free from pain. The premenstrual dysmenorrhea begins a few days after the postmenstrual pain has stopped. The maximum intensity of pain coincides with the menstrual flow. These patients offer a real problem in therapy. Twenty patients have reported premenstrual dysmenorrhea of ten to fourteen days' duration. We present this series of cases to illustrate the complexity of our problem.

We will now briefly analyze the group of forty patients who have stated that dysmenorrhea was present before the onset of poliomyelitis.

A similar classification, as was previously used to express the severity of dysmenorrhea before poliomyelitis, is expressed in Table 12.

Twenty-one patients of this group described the pain as mild.

Only four of the group described the pain as being very severe.

Referring to Table 13, it illustrates a very important observation, namely, that thirty-seven of the forty patients in this group had either a definite increase in the dysmenorrhea or a recurrence, following a symptom-free interval.

Two patients reported no change in the intensity of the pain following poliomyelitis, but definitely stated that there was a marked change in the character of the dysmenorrhea. Prior to poliomyelitis it had been intermittent and cramp-like. After the disease it was described as very intense and constant. The last case in this series has previously been reported. Dysmenorrhea entirely disappeared after the onset of poliomyelitis.

An analysis of the group of thirty-seven patients reporting an increase in menstrual pain after the onset of poliomyelitis is illustrated in Table 14. Here we note that eight patients had symptom-free intervals of one to seven years prior to the disease. One patient of this group had very severe dysmenorrhea between the ages of fourteen and eighteen, which stopped spontaneously. The remaining seven of this group had dysmenorrhea cured by various types of surgery before the

TABLE 14.—*Illustrates the Increase or Recurrence of Dysmenorrhea Following Poliomyelitis*

25—Marked increase in dysmenorrhea after poliomyelitis.
4—Slight but definite increase.
8—No dysmenorrhea immediately preceding poliomyelitis (free interval of one to seven years).
1—Very severe dysmenorrhea—14 to 18 years of age. Stopped spontaneously.
7—Dysmenorrhea cured by surgery.

37

onset of poliomyelitis. The operations enumerated were: dilatation and curettage, ligament suspension of the uterus, resection and removal of the ovaries.

Twenty-five patients reported a marked increase in pain.

Four patients stated that there was a slight but definite increase.

The four patients who complained of very severe dysmenorrhea before the onset of poliomyelitis present an interesting analysis. They have been previously reported in our series, but it is of especial interest to call attention to the status of pain immediately preceding the disease.

One patient belongs to the group reporting no change in the intensity, but a definite change in the character of the pain. The other three patients did not have dysmenorrhea for at least one year prior to the onset of poliomyelitis.

COMMENT

It is quite apparent from this analysis that the symptom of dysmenorrhea following poliomyelitis is as definite in the group reporting dysmenorrhea before the disease as it is in the series of patients who had not previously experienced painful menstruation. Irregularities in interval, duration, and character of menstrual flow, were also reported in this group of forty patients, but they are similar to the examples previously given. In this series of forty patients, twenty-one reported other menstrual irregularities in addition to dysmenorrhea.

The records presented have, of necessity, been based entirely upon personal histories as given to us by the patients interviewed. Inaccuracies are inevitable. Exaggeration of symptoms must be recognized and, where possible, proper evaluation given them. We have made every effort to do this in compiling our data. It is a well-known observation that any severe or prolonged illness lowers the threshold to pain, resulting in a marked diminution in pain tolerance. These points are especially applicable in our study of this epidemic of poliomyelitis. Many of these patients have spent months on a Bradford frame or in various types of plaster casts. All have been on absolute bed rest during the acute phase of the illness, frequently being required to have a board placed under the mattress. These necessary expedients in treatment have unquestionably contributed in lowering the pain tolerance to dysmenorrhea. Psychoneuroses have been prominent features in this epidemic and, consequently, are important as contributory agents in the production of dysmenorrhea. We are well

TABLE 13.—*Analysis of Forty Patients—Dysmenorrhea Prior to Poliomyelitis*

37—Definite increase or recurrence of dysmenorrhea.
2—No change in intensity. Definite change in character of the dysmenorrhea.
1—No dysmenorrhea following poliomyelitis (previously reported in this series).

40

aware that normal, healthy activity, is one of the essential conditions prerequisite to successful treatment of menstrual dysfunctions, particularly dysmenorrhea.

However, since we have noted that this symptom has continued into the convalescent periods, and is still a major problem after these patients have returned to duty, we cannot help but feel that this particular epidemic of atypical poliomyelitis must be recognized as the etiologic factor in producing the various types of abnormal menstruation encountered. We realize that, from the gynecologic standpoint, we are dealing with a complex problem.

The atypical menstrual histories presented have almost run the complete gamut of the so-called functional types of abnormal menstruation. We have seen a predominance of the one symptom, dysmenorrhea. It has occurred as a new symptom in a previously normal menstrual history and as a markedly exaggerated manifestation of previously existing dysmenorrhea. We have seen excessive menstrual flow become scant or entirely absent following poliomyelitis. In one instance we have seen abnormal menstruation become perfectly normal after the onset of the disease.

We do not presume to make definite statements in regard to the *modus operandi* of this disease process, as it apparently affects menstruation. It will require infinitely more time and more accurate data to properly evaluate these findings. Our observations have been made after a comparatively brief study. It does seem logical, however, to assume that all of the menstrual irregularities encountered can be explained on the basis of endocrine gland dysfunction. In the study of these patients, we have seen ample evidence of thyroid gland involvement, as demonstrated by the high incidence of lowered basal metabolic rates following poliomyelitis. We have seen definite pituitary gland involvement, as evidenced by the sudden appearance of abnormal hair distribution, simulating the male type. This was seen in two instances following the disease in perfectly normal patients. There had never been any indication of abnormalities of this gland prior to poliomyelitis. The overwhelming evidence of ovarian dysfunction is illustrated in the multiplicity of abnormal menstrual reactions.

The very bizarre nature of the menstrual changes following poliomyelitis leads one to logically explain them entirely on an endocrinologic basis. Each patient presents an individual story, probably depending upon the gland or group of glands primarily involved in the process. We can do no more than speculate on the exact process by which these changes are brought about. It is possible that the disease process itself, in some manner, directly acts on these glands. This statement would seem to be substantiated by the findings of one group of workers, who have noted marked cystic degeneration of the ovaries. This observation was made during ten laparotomies which they performed on postpoliomyelitis patients. Whether this will prove to be a consistent finding remains to be seen. It cannot be given credence on the

basis of ten observations. The long period of premenstrual dysmenorrhea, as seen in twenty-three patients in this series, would tend to corroborate the statement that ovarian dysfunction is an important factor in producing painful menstruation. In this group the long premenstrual phase of the dysmenorrhea coincides with the ovulation stage in the ovarian cycle.

These changes might also have been produced as a result of an indirect action on the endocrine glands through the sympathetic and parasympathetic nervous systems. The exact nature of this process is as yet not clearly understood. We have previously noted the apparent involvement of the sympathetics and parasympathetics in producing the atypical types of paralyses exhibited in the acute stages of this disease. We can do no more than theorize until more accurate data and knowledge are available.

TREATMENT

Our discussion of treatment must, of necessity, be brief and inconclusive. Interest has been concentrated primarily on the treatment of the poliomyelitis, as it rightfully should be. The complications and sequelae have not been thoroughly investigated, and treatment has been inadequate in many instances. This statement is in no way to be construed as a criticism of the men who have done such creditable work in the care of these patients. In brief, it can be stated that treatment of the gynecologic symptoms, particularly of dysmenorrhea, has not been outstandingly successful. A few patients have recovered without any specific medication. A few have responded very satisfactorily to the standard glandular preparations used. Response to treatment in the great majority, however, has been rather discouraging.

Apparently, the majority of these patients fall into the group of the so-called primary type of dysmenorrhea, since gross pelvic pathology has been conspicuously absent. The treatment would then logically follow the general principles as outlined by McNeile, Pettit, and Emge, in a recent symposium on dysmenorrhea, published in the February, 1936, issue of CALIFORNIA AND WESTERN MEDICINE. This would include the appropriate use of glandular products, plus the establishment of a normally active regimen of daily habits. Proper diet, exercise, and rest should be included, as well as attention to the specific problem presented. Surgery should be resorted to only in the event that definite evidence of pathology is established. The great variety in types of abnormal menstruation indicates that, for successful therapy, each patient must be individualized and treated accordingly. They do not follow any set pattern for which a general panacea can be used. This fact alone probably accounts for the discouraging responses to treatment to date. It is hoped that in the near future we may be able to present accurate information regarding the specific treatment of these patients, the products used and the responses to them.

We present this brief survey, not as a statistical report, but as an introduction to a problem which

we feel must be carried on to its logical conclusion, namely, to return these patients to their various occupations healthy and symptom-free.

CONCLUSIONS

In closing, permit us to again state that, as a result of our survey, we are convinced of the following facts:

1. The Los Angeles epidemic in 1934 and 1935 of so-called acute anterior poliomyelitis presents an entirely atypical picture of the disease.

2. It resembles a combination of poliomyelitis and encephalitis, with a preponderance of neurogenic and psychogenic symptoms. Convalescence has been slow, and patients have frequently been left with marked emotional instability.

3. There is justifiable evidence to establish a definite involvement of the sympathetic and parasympathetic nervous systems.

4. The survey has conclusively demonstrated that the disease has produced a large variety of menstrual irregularities.

5. Dysmenorrhea has been the most prominent gynecologic complaint, and has been present in 85 per cent of the case histories analyzed.

6. The dysmenorrheas are apparently of the primary type, based on dysfunction of the endocrine glands. Psychoneuroses are important as probable etiologic factors in producing the symptom of dysmenorrhea.

7. Treatment of the gynecologic problem has not been entirely satisfactory to date. It has been inadequate for the most part, largely due to the lack of individualization of the case histories as presented. These records must be more carefully studied in order to properly outline the course of treatment indicated in each instance.

8. We feel that we are dealing with a very important problem, both medically and economically, and present this survey in the form of a preliminary report in the hope that it may be of use in the future observations of poliomyelitis and its sequelae.

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DISCUSSION

DONALD G. TOLLEFSON, M. D. (511 South Bonnie Brae, Los Angeles).—The discussion that Dr. Dwight Young presents is an entirely new phase of the complications following acute anterior poliomyelitis.

With an atypical epidemic, such as occurred in Los Angeles in 1934-1935, it might be justified to consider the symptoms as due to involvement of the sympathetic and parasympathetic nervous systems. It must also be remembered that patients who are ill for a long period of time develop certain psychoneurotic tendencies which must be considered in discussing etiology. Surgery of the sympathetic system for certain types of dysmenorrhea has been practiced quite extensively during the past few years, and if we are dealing with a disease or involvement of this system, probably the operation will be of great benefit in these cases.

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MARGARET SCHULZE, M. D. (University of California Hospital, San Francisco).—The dysmenorrhea which Doctor Young describes following poliomyelitis is certainly an unusual sequel, and I have had no personal experience with this type of case. In an endeavor to determine whether such cases had occurred in the bay region, Dr. Frances Baker has kindly questioned for me the patients with poliomyelitis sequelae now receiving treatment

in the orthopedic department of the University of California clinic. Of twenty-five such patients, many with severe residual paralyses, replies were obtained from eighteen, none of whom had severe dysmenorrhea, although three complained of mild and one of occasional moderate discomfort. In addition, through the courtesy of Dr. Ruby Cunningham, Dr. Lois Brock has reviewed the histories of 1,200 freshmen women at the University of California. Sixteen gave a history of poliomyelitis and of these, three stated that they had severe pain at the onset of the period. None of these three had had their poliomyelitis in the 1934 or 1935 epidemics, and this incidence of dysmenorrhea is not greater than that in the group as a whole.

The etiologic factors are difficult to evaluate, and one cannot escape the conclusion that the psychogenic element may be very important. However, with the definite evidence of endocrine disturbance in many of these women, further studies from this standpoint should be interesting, particularly hormonal studies and endometrial biopsies. In view of the very severely disabling character of the symptoms and the evidences of involvement of the sympathetic nervous system, some of these patients might come up for consideration of presacral sympathectomy should they fail to respond to the therapy which Doctor Young has outlined. It will be interesting, therefore, to hear of his further studies on these patients.

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L. A. EMGE, M. D. (2000 Van Ness Avenue, San Francisco).—Doctor Young's survey is of considerable historical and clinical interest. I am not equipped to discuss the Los Angeles epidemic relative to its relation to orthodox poliomyelitis. It is sufficient that we recognize it as a wasting disease which influences the nervous system and leaves demonstrable motor damage. It is well known that most wasting diseases influence menstruation, usually producing either a menstrual depression or painful menstruation. Nothing is known about the mechanism of this disturbance. The type of dysmenorrhea which follows wasting disease is very similar to that which occurs in asthenic, undernourished, and anemic individuals. It frequently disappears without treatment after a normal metabolic balance has been established. In the particular group that Doctor Young has so ably discussed, one would be tempted to interpret the pain production on the basis of an upset in the sympathetic nervous system. However, it is extremely difficult and involved to build up a theory of the localization of nerve damage. Experimentally, it has been demonstrated that wasting disease can produce a degeneration of the ganglia of the sympathetic plexus of the pelvis, and that this degeneration can be arrested and probably improved by the administration of estrogenic hormones. It also has been demonstrated that the withdrawal of this group of hormones leads to an atrophy of the sympathetic ganglia. One might, therefore, theorize that the actual damage to the nervous system in the disease under discussion may in reality occur in the sympathetic pelvic innervation as a part of a general nerve disturbance occurring in poliomyelitis. I am rather skeptical about the evaluation of the severity of pain in dysmenorrhea as the result of a group study. Long experience has taught me that no two patients ever evaluate pain alike. I base my own standard on the ability of the patient to remain ambulatory during menstruation. If the patient has to take to her bed, menstruation becomes a serious hindrance to her physical and functional happiness. All other attempts at grading menstrual pain are subject to so many controversial points that it is better not to attempt to use them for statistical purposes. What interests me particularly in Doctor Young's paper is that nearly half of his patients had some form of dysmenorrhea prior to falling ill, and that some of these who had been free from this disturbance for some periods just preceding their illness suffered a recurrence. It would be interesting to learn if the period of freedom occurred during a period of particularly good physical health. It would prove the point that disturbed health and dysmenorrhea go hand in hand. Doctor Young's comment that dysmenorrhea occurring in connection with poliomyelitis may be due entirely to an endocrinologic disturbance is a rather dangerous deduction for which he can present no proof. What his study proves is that poliomyelitis, like other wasting diseases, is frequently followed by dysmenorrhea.

CERVICAL REPAIR IMMEDIATELY FOLLOWING CHILDBIRTH*

By ABRAHAM BERNSTEIN, M.D.
San Francisco

DISCUSSION by H. A. Stephenson, M.D., San Francisco; Alice F. Maxwell, M.D., San Francisco; E. M. Lazard, M.D., Los Angeles.

THE safety of labor in a properly managed maternity, with a staff of adequate experience and skill, has of late years become so great that the mortality approaches the vanishing point.

Proper prenatal care has aided in greatly diminishing the toll taken by toxemia. Hospital asepsis has done away with puerperal septicemia, and the well-trained obstetrician conducts his case in such a manner that hemorrhage does not occur, and if it does occur, the necessary measures are immediately instituted. The results, so far as mortality is concerned, are exceedingly gratifying.

Now, although we have brought our mortality rate down, we are still lacking in the attention given to some of the common lesions caused by labor.

OBJECT OF THIS PAPER

The object of this paper is not to present anything new, but to revive an old discussion as to the advisability of repairing a torn cervix while suturing a lacerated perineum following childbirth. It is the aim of every obstetrician to give the pregnant woman the best prenatal care, and to leave her in good physical condition after childbirth; but he does not accomplish this if the healing of a torn cervix is left to nature. Active bleeding from the cervical artery of the uterus is practically the only condition which most practitioners consider the indication for immediate repair of cervix. Even then many resort to tightly packing the vagina with gauze, in the hope of controlling the hemorrhage. We consider the chances of infection are much greater when this is done than when a bleeding artery is sutured or ligated. Today the danger of infection has been greatly minimized owing to the fact that obstetrics is considered major surgery, and the patients are given the same attention and preparation that other major surgical cases receive.

In the absence of an alarming hemorrhage from a lacerated cervix, the attending physician generally ignores the cervical condition, and proceeds with the repair of the perineum regardless of whether it is a first, second, or third degree tear. This, however, is contrary to modern surgical procedure. It is, indeed, very poor and incomplete surgery to correct one pathologic condition and neglect another adjacent to it.

If there is infection present or suspected, or if the cervix is too edematous or macerated to warrant immediate repair, it is best to swab raw surfaces with two per cent iodine solution or tincture of mercuric iodine, and then wait a few days. If the

* From the Department of Obstetrics and Gynecology, University of California Medical School.
Read before the San Francisco County Medical Society, Section on Surgery, August 18, 1936.

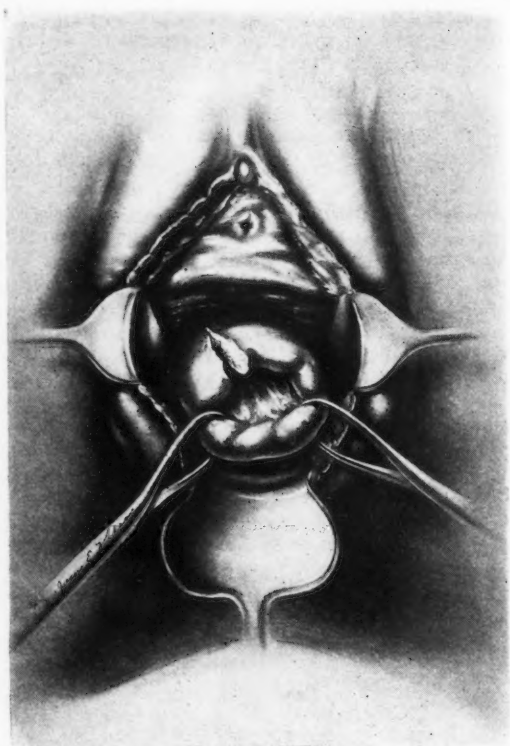


Fig. 1.—Lacerations of cervix.

patient's temperature remains normal, and no signs of infection appear, the cervix and perineum may then be repaired.

The cervix is torn in almost every labor, but the amount of damage varies from a slight nick to deep lacerations into the vaginal fornices. The tears may be multiple, unilateral, bilateral, stellate, anterior, posterior, or annular.^{1,3}

The most common causes of the damage to the cervix and the surrounding tissues are precipitate labor, premature rupture of membranes, a rigid cervix, injudicious use of pituitrin, using forceps, or extracting the head coming after, before complete dilation of cervix, rapid manual or instrumental dilation and incarceration of anterior lip of the cervix between the pelvis and the presenting part of the fetus.² Usually the cervical laceration, if small, will heal of itself. In view of this we make it a practice not to repair the cervix if laceration is less than three-fourths of an inch in length and if there is no bleeding. Lacerations which are more extensive are immediately repaired. (Fig. 1.) If this is not done, the circular

TABLE 1.—Total Number of Cases and Parity

Year	Total Number of Cases	Primipara	Multipara
1930	190	84	106
1931	121	69	52
1932	104	60	44
1933	95	61	34

TABLE 2.—*Types of Delivery*

Number of Cases	Spontaneous	Breech	Forceps	Cesarean Section
190	139	3	47	1
121	75	6	35	5
104	67	4	23	10
95	41	4	37	13

muscle fibers of the cervix retract, and the raw surfaces will then granulate over and become covered with squamous or columnar epithelium, leaving a very much eroded, scarred cervix; also this type of cervix in later years may be the forerunner of an epithelioma. Because of this we may get such pathologic conditions as cervical and uterine hyperplasia, and engorgement resulting in displacement

TABLE 3.—*Cervical Repairs*

Year	Spontaneous Deliveries	Forceps	Breech
1930	40	41	1
1931	25	36	3
1932	23	18	3
1933	18	31	2

of the uterus, chronic parametritis, and other low-grade pelvic infections. These give rise to backache, headache, constipation, nervousness, leukorrhea, metrorrhagia, and dysmenorrhea.^{2,4}

AUTHOR'S STATISTICS

During the past four years, we have sutured the torn cervix before repairing the lacerated peri-

TABLE 4.—*Induction of Labor*

Year	Total Cases	Premature Rupture of Membrane	Pituitrin Used to Induce Labor
1930	190	15	26
1931	121	10	17
1932	104	12	16
1933	95	6	8

Note: No cervical repairs in above cases.

neum, and thus far we have had no reason to regret this procedure, as our results have been uniformly satisfactory and successful.

Tables 1 to 8 show the different types of cases we had and the number of cervical repairs.

From the tables presented it will be seen that we do not get 100 per cent results, but because of that it does not seem a valid reason for not

TABLE 5.—*Total Cervical Repairs*

Year	Total Cases	Total Cervical Repairs
1930	190	82
1931	121	64
1932	104	44
1933	95	51

TABLE 6.—*Morbidity With Cervical Repair*

Year	Total Cervical Repairs	Highest Temperature	Highest Pulse
1930	82	37.3	108
1931	64	37.2	106
1932	44	37.3	108
1933	51	37.4	104

Note: Above taken first twenty-four hours, following which temperature and pulse dropped to normal.

preventing as much pathology as we can. Ectropin and erosion, if not too extensive, may be greatly improved by the use of a small electric cautery or 20 per cent silver nitrate.

COMMENT

From these tables it is readily seen that spontaneous deliveries give us lacerations of the cervix as well as operative interferences. One expects to find lacerations of the cervix following operative interferences. However, our inspection and careful observation of these cases show that all

TABLE 7.—*Morbidity Without Cervical Repair*

Year	No Cervical Repairs	Highest Temperature	Highest Pulse
1930	108	37.4	110
1931	57	37.2	106
1932	60	37.3	108
1933	44	37.2	106

Above: First twenty-four hours following delivery.

cervices should be examined following delivery. This should be done whether there is an excess amount of bleeding or not. Naturally, if the patient is bleeding, one examines the perineum first and then looks to the cervix for possible trouble.

From Table 4 we get the number of cases with premature rupture of membranes and the cases induced with pituitrin. However, although everyone agrees that the above factors aid in lacerating a cervix, in our small series we had no lacerations resulting from either factor.*

AUTHOR'S PROCEDURE

Our procedure is as follows: Under anesthesia, the patient is placed in the exaggerated lithotomy position, an assistant holds each leg and flexes the thighs on the abdomen. Under direct light,

* See Figures 1 and 2 of lacerated cervix, and repair.

TABLE 8.—*Follow Up Eight Weeks After Delivery*

Year	Total Cervical Repairs	Cervix Well Closed	Ectropin and Erosion of Cervix
1930	82	71	11
1931	64	58	6
1932	44	37	7
1933	51	42	9

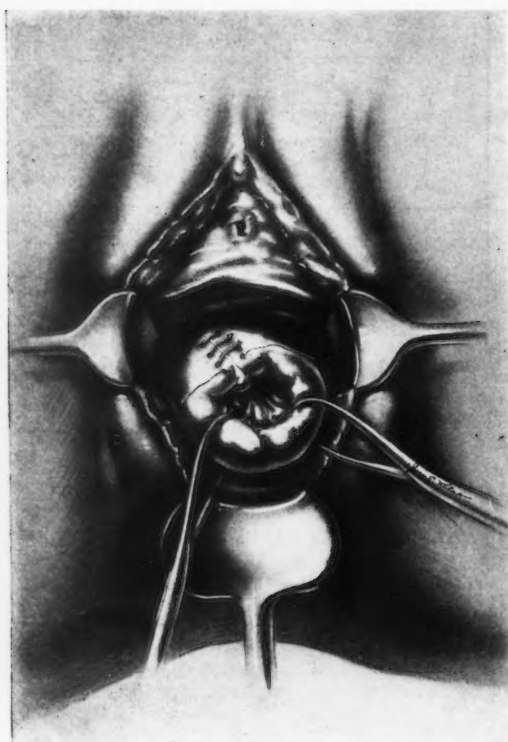


Fig. 2.—Method of repair of lacerations of cervix.

lateral retractors are inserted and the cervix is grasped with a sponge stick and brought into field of operation. (See Fig. 2.) It is easier to inspect and grasp the torn cervix before the expulsion of the placenta, for after the delivery of the placenta the uterus is massaged until it is firmly contracted and the uterine hemorrhage has ceased. The patient is then given one cubic centimeter of pituitrin hypodermically. After careful cleansing of the vagina, the lateral retractors are reinserted and the cervix again pulled down and examined. Sponge sticks are readjusted and the cervix pulled in the direction opposite to the laceration. Good exposure is obtained and the tear is repaired with interrupted No. 2 chromic sutures. Enough sutures are used to insure complete hemostasis and good coaptation. The knots of the sutures should not be tied too tight because allowance must be made for shrinkage of the cervical tissues, and care must also be taken to insure good drainage and to leave the cervical canal patulous. All cervical lacerations are treated in the same way. No vaginal drains or packing are used, unless there is danger of an adhesion forming between the cervix and the lateral wall. The drain is left in for twelve hours. The perineum is then inspected and repaired if necessary.

IN CONCLUSION

1. All cervixes should be inspected following delivery.
2. If cervical lacerations present over one inch long, they should be repaired.

3. Cervical lacerations occur with normal spontaneous deliveries as well as operative cases.

4. Cervical repairs lessen the danger of pathologic lesions occurring later in life.

5. No repairs should be done in the presence of infection.

350 Post Street.

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DISCUSSION

H. A. STEPHENSON, M. D. (490 Post Street, San Francisco).—The author has shown two things very clearly: The high percentage of torn cervixes following delivery, and the comparative safety of inspection and repair of such cervixes when done according to the author's technique.

Regarding the first, the incidence is very surprising. In spontaneous deliveries one cervix in every three required repair. It is very difficult to explain his high percentage on the basis of the causes of lacerated cervix, as set forth in the paper. Even more surprising is the fact that only 11 per cent of the forceps cases were without laceration. Accepting the figures given by the author, it would seem to make almost imperative the inspection of every cervix immediately following delivery. This has not been the practice of most obstetricians, as the cervixes examined at postpartum examination some weeks after delivery are mostly not lacerated to a degree which would be considered as grossly pathological. Microscopical pathology is undoubtedly present to some degree in both the repaired and the unrepaired groups. Lack of facilities and assistants also makes difficult such routine examination. Many patients are still delivered in surroundings in which good asepsis cannot be rigidly observed. This is deplorable, but nevertheless a fact.

The success attained by Doctor Bernstein in this series should be a stimulus to all physicians to immediately repair cervical lacerations following delivery when they have at hand facilities which permit such repairs to be done without subjecting the patient to undue risk of infection.

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ALICE F. MAXWELL, M. D. (University of California Hospital, San Francisco).—It has long been an accepted dictum that the standards of adequate obstetrical care are met by the maintenance of the woman's health and the prevention of complications during pregnancy, labor, and the puerperium; by the delivery of a healthy child; and by the restoration of the pelvic tissues to their normal nonpregnant condition. This report is limited to a discussion of the correction of cervical damage which may occur in spontaneous delivery, and which inevitably develops after trauma incidental to operative procedures, or the institution of procedures during labor for the purpose of hastening cervical dilatation. The author is to be congratulated on the satisfactory end-results obtained by postpartum repair of cervical lacerations in a group of private patients with a well-controlled surgical technique.

It is obvious that cervical tears which are causing postpartum hemorrhage demand immediate suture; however, the advisability of the routine inspection of the cervix following labor, in the absence of hemorrhage or factors which may contribute to cervical trauma, has not been universally accepted. The ever-present threat of introducing uterine infection must be balanced against the advantages of visual inspection of the cervix. The author's results justify the conclusion that with adequate exposure of the postpartum birth tract, and a rigid surgical technique, the prompt repair of cervical tears does not increase the incidence of puerperal infection. Our interest in cervical lacerations is focussed not only on their bearing on puerperal morbidity, but on the more remote effect of such tissue injury to the subsequent development of

carcinoma. The architecture of the cervical canal is such that drainage of the complex glands is not complete in the presence of the trauma of even physiologic dilatation, gland stasis favors the introduction, propagation and spread of organisms, and serves as a nidus of long-continued irritation with resultant permanent tissue alterations. It must be emphasized that this condition may prevail in the cervical canal in the absence of tearing of the cervical tissues apparent to inspection. Postnatal follow-up examinations only will reveal the extent of the tissue changes and determine the methods to be instituted to eliminate infection. It is not the laceration *per se*, but the associated infection which is the important predisposing factor in the development of carcinoma. The elimination of infection by the repair of lacerations, the removal of infected tissues of the canal by surgical or coagulation methods, are forward steps in the prevention of cervical cancer.

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E. M. LAZARD, M.D. (1930 Wilshire Boulevard, Los Angeles).—I have read Doctor Bernstein's paper with great interest, as I have not made it a practice to do immediate cervical repairs, except for deep lacerations which cause hemorrhage which has to be controlled. For such cases I never depend on packing, but always control with sutures. If the nature of the delivery is such that deep lacerations are present, I prefer to wait for from five to seven days, when swelling and edema from the trauma of delivery have subsided and involution has begun. I have felt that better plastic results could be obtained than by the immediate repair. In the average case of normal delivery, the six-week postpartum examination usually reveals very little laceration or erosion, and what there is can be well cared for by linear cauterization. Of course, where there has been a difficult version or forceps delivery, deep lacerations are comparatively frequent. With Doctor Bernstein, I believe that routine inspection of the cervix after delivery should be done, and in view of his favorable results, I feel that immediate repair of deep lacerations should be done, provided the patient is in a hospital where the proper aseptic technique can be obtained.

MENORRHAGIA: THE RESULTS OF RADIUM TREATMENT—A FOLLOW-UP STUDY *

By MARGARET SCHULZE, M.D.
San Francisco

DISCUSSION by Edward N. Ewer, M.D., Oakland; J. Morris Slemons, M.D., Los Angeles; Erle Henriksen, M.D., Los Angeles; C. Frederic Fluhrmann, M.D., San Francisco.

THE treatment of menorrhagia has always been a difficult problem in gynecologic therapy. With the development of the use of radium in gynecology, it was hoped for a time that this problem had been solved. It was soon found, however, that although in many cases the results were brilliant, in others the treatment was unsuccessful, or there were undesirable sequelae.

CLINICAL MATERIAL

It was with the hope of establishing definitely the limitations of this therapy, as well as determining the most desirable dosage to effect certain results, that this study was undertaken. It constitutes a follow-up upon the results of radium therapy in 204 women observed over a period of at least two years, and up to twenty years. Follow-up

notes made upon succeeding clinic visits were utilized in all cases. In addition, a questionnaire covering the main points of information we wished to obtain was sent to all patients, and if there was any indication of dissatisfaction with the results of treatment from the questionnaire, the patient was requested to return for reexamination and an interview, to determine the exact nature of her difficulties.

Only cases of so-called functional menorrhagia—that is, those in which there were no determinable gross pathologic lesions, are included in this study. The women ranged in age from fourteen to sixty years. Only one woman was over fifty-three years; but as she had menstruated without interruption, although irregularly, up to sixty years of age, it was felt that she belonged in the group. There were six young girls in the adolescent group under twenty years of age, 136 women in the adult group from twenty to forty-five years, and sixty-two women in the menopausal group of forty-five years and over.

TABLE 1.—Incidence by Ages in 204 Patients

Age	Number
14-20	6
20-45	136
45-60	62

For certain purposes of study, the adult group has been further subdivided into a young adult group of forty-five cases from twenty to thirty-five years, and a premenopausal group of ninety-one cases from thirty-five years up to forty-five years.

The duration of symptoms is indicated in Table 2.

TABLE 2.—Duration of Symptoms

	Adolescent Group	Adult Group	Menopause Group
One month or less	0	7	6
One month to one year..	1	38	26
One to five years	4	58	20
Five to twenty years	1	33	10

The type of periods is indicated in Table 3.

TABLE 3.—Type by Periods

	Regular	Irregular	Continuous
Adolescent	0	0	6
Adult	27	69	40
Menopausal	3	40	19

By continuous bleeding is meant a duration of at least one month. Four of the patients had bled constantly for a period of from one to three years.

* From the Department of Obstetrics and Gynecology, University of California Medical School.

Read before the Obstetrics and Gynecology Section of the California Medical Association at the sixty-fifth annual session, Coronado, May 25-28, 1936.

Physical evidence of dyscrasia of the glands of internal secretion was relatively rare in this series, and is indicated in Table 4.

TABLE 4.— <i>Gland Dyscrasia</i>				
	Obesity		Hirsutism	Skin Change
	Mod.	Ext.		
Adolescent	1	0	0	0
Adult	18	6	5	3
Menopausal	15	2	1	0
Adults—Breast atrophy 10, goiters 4, diabetes 1, dwarfism 1.				

The basal metabolism has been taken as a routine only relatively recently, with the results that are shown in Table 5.

TABLE 5.— <i>Basal Metabolism</i>			
	Normal	Over Plus 10	Below Minus 10
Adolescent	1	1	1
Adult	15	2	10
Menopausal	1	1	1

The marital status of the patients is indicated in Table 6.

TABLE 6.— <i>Marital Status</i>			
	M.	S.	W.
Adolescent	0	6	0
Adult	110	18	8
Menopausal	56	0	6

The number of women who had pregnancies before and after radiation is indicated in Table 7.

TABLE 7.— <i>Pregnancies</i>		
	Pregnancies Before Radiation	Pregnancies After Radiation
Adolescent	0	0
Adult	100	7
Menopausal	60	0

Only four of the women who had pregnancies after radiation went to term. Two had spontaneous and one an induced abortion. These cases will be discussed in more detail later.

Many of the patients had been unsuccessfully treated elsewhere before coming to us. Previous treatment is indicated in Table 8.

TABLE 8.— <i>Previous Treatment</i>				
	Medi-cal	Glandu-lar	Surgi-cal	Radia-tion
Adolescent	1	1	6	1
Adult	6	2	15	1
Menopausal .....	..	1	2	..

Surgical treatment consisted of dilatation and curettage in all except two of the adult cases where the patients had uterine suspensions, in addition to dilatation and curettage. Four cases had been curetted three times, and one patient four or five times before we saw her. A number had had gynecologic surgery for other conditions before the onset of their menorrhagia. This surgery is not included in the tabulation.

The results of the initial treatment with radium are given in Table 9.

TABLE 9.— <i>Results of Initial Treatment</i>			
	Insuf-ficient	Satis-factory	Over-treated
Adolescent	6	0	0
Young adult	21	18	6
Premenopausal	23	59	9
Menopausal	1	57	4

Overtreatment is rather difficult to define accurately, and its conception varies considerably with the age of the patient. In general, we have considered amenorrhea, or very infrequent and scanty periods, as evidence of overtreatment in the adolescent group and in the young adults under the age of thirty-five; whereas in women over this age it was not so considered, unless the patient herself made complaint, whether as the result of atrophic, vaginal changes, psychic changes, or severe menopausal symptoms.

The type of further treatment is given in Table 10.

TABLE 10.— <i>Further Treatment for Menorrhagia</i>					
	Ra-dium	X-ray	Sur-gery	Endo-crin	Medi-cal
Adolescent ..	3	1	2	3	2
Young adult	11	0	5	7	4
Premeno-pausal	5	7	5	3	1
Menopausal ..	0	1	0	0	0

Since certain patients received more than one type of further treatment, and one or two had no further treatment, although their menorrhagia was not controlled by the initial one, Table 10 is not exactly comparable with Table 9.

Most of the surgical treatment was done elsewhere on patients who had moved to distant locali-

ties, or who were so dissatisfied with our results that they did not return to us. Of the adolescents, one had three further curettages, and later x-ray and radium. Another had much endocrine treatment, and then a curettage and a presacral sympathectomy for pelvic pain. Of the young adults, four had hysterectomies, all done elsewhere, and one had a large cervical polyp removed by us. Two of the hysterectomies followed repeated radiation. Of the premenopausal women, four under forty had hysterectomies, one after repeated radiation. Three were done elsewhere, and one was done by us because of the development of multiple fibroids and an ovarian cyst. One woman in the forty to forty-five group had a later curettage. Later pelvic surgery for other reasons than menorrhagia was done in six cases.

The final result of all treatments is given in Table 11.

TABLE 11.—Final Result—All Treatments			
	Insufficient	Satisfactory	Overtreated
Adolescent	0	2	4
Young Adult	3	27	15
Premenopausal	3	78	10
Menopausal	0	58	4

The criteria for overtreatment are the same as in Table 9. Hysterectomies in women under thirty-five are considered overtreatment, those in women over thirty-five were not so classified when the patient was satisfied.

The incidence of menopausal symptoms is given in Table 12.

TABLE 12.—Incidence of Menopausal Symptoms			
	Mild	Severe	None
Adolescent	0	0	6
Adult	29	23	84
Menopausal	14	8	40

Contrary to the generally accepted opinion, severe menopausal symptoms after radiation were relatively infrequent.

The weight changes after radiation are given in Table 13.

TABLE 13.—Weight Changes After Radiation			
	Gain	Loss	Unchanged
Adolescent	4	2	0
Adult	73	16	35
Menopausal	25	7	12

In sixty-eight women the gain in weight was moderate, below 20 pounds. Thirty-four women showed marked gain in weight, from 20 to 75 pounds. The greatest weight loss was 40 pounds, and a large number of the women who lost weight stated that they did so by dieting.

Changes in sexual function and atrophic changes which might lead to these are noted in Table 14.

TABLE 14.—Atrophic and Psychic Changes			
	Frigidity	Dyspareunia	Vaginal Atrophy
Adolescent	1	0	0
Adult	7	9	22
Menopausal	2	2	9

It is probable that the changes indicated in Table 14 are more frequent than are indicated by the table, since this information was not requested in the questionnaire, but was volunteered by the patients in a number of cases, with very bitter complaints over the marital difficulties which arose. Later inquiry of a number of patients who were dissatisfied with the results of their treatment, but were very vague in stating why, showed that their dissatisfaction was of this nature. Vaginal atrophy was undoubtedly far more frequent than noted here, but so taken for granted after the artificial menopause that special note was not made of it.

TUMOR GROWTH

Since functional menorrhagia is now generally considered due to disturbed endocrine function, and since some of the more recent theories of tumor etiology relate tumors to disturbed endocrine function also, it was very interesting to see how many of our cases on later examination had developed tumors. Uterine fibromyomata were found by us on later examination in four cases; in one case in two years, in two cases in three years, and in one case thirteen years after the original treatment. In one of the three-year cases it was symptomless, in the other three cases menorrhagia recurred. In a fifth case, menorrhagia recurred four months after our radium treatment, and the "uterus and a tumor" were removed by another physician seven months later. In two cases ovarian cysts later developed—in one case complicating one of the fibromyomata mentioned above; in another without recurrence of the menorrhagia. Three cases later developed cervical polpi. Two women later developed carcinoma of the breast. Both were unmarried and had never been pregnant.

Three women developed diabetes during the course of the follow-up observation.

PREGNANCY

Since pregnancy followed radiation so rarely in this group, the cases that became pregnant later merit special mention. There were seven, all in the young adult group, from twenty to thirty-four years of age inclusive. None of the adolescents

no gross pelvic lesions. In addition to the difficulties which Doctor Schulze has pointed out, it must also be remembered that irradiation may result in damage to germ-plasm, which can manifest itself in succeeding generations. It is true that many women have had normal children after such treatments, but time only can tell if an injury will not produce some defect in the offspring of the second and third generations. It certainly has been amply demonstrated in insects and there is good evidence that it may occur also in mammals.

On the other hand, the use of radium for the treatment of functional uterine hemorrhage in women of the menopausal age is an effective and comparatively safe method of therapy. We prefer the use of radium to x-ray since it gives an opportunity to do an extensive curettage and thus definitely eliminate the possibility of an existent carcinoma of the fundus uteri. The dosage employed varies from 1,200 to 1,500 mghrs. The bleeding is immediately controlled in the vast majority of instances, although a slight show may at times persist for some days or weeks. In the few rare failures it has been necessary to perform a hysterectomy subsequently. One of my patients returned with a carcinoma of the fundus uteri seven years after radium therapy, so this possibility must also be kept in mind.

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DOCTOR SCHULZE (Closing).—A careful review of the pathology, with elimination of all but those conditions due to functional endometrial changes, was, of course, made in all this group, but limitation of time did not allow of its discussion here.

In general, the results in the older women were entirely satisfactory, and many wrote that they had never felt so well. A few, however, particularly of those whose menorrhagia had not been of long standing, or very troublesome, were intensely dissatisfied with the abrupt cessation of their functional activity. In the younger women, the fact that we were entirely unable to predict what may happen with a given dose of radium, and that we are so helpless to combat the results of overtreatment, must make us hesitate to employ it, except possibly as a measure of last resort. Several of the younger women, who had had long and serious bleeding, were at first delighted with their amenorrhea, or scanty periods, and their ability to resume the normal activities of youth; yet, later, wandered from doctor to doctor in an effort to overcome sterility or dyspareunia.

The possibility of damage to germ plasm, even in the first generation, is suggested by the one hydrocephalic among the comparatively small number of pregnancies following radiation in the series, and is an additional reason for being extremely cautious in its use. We feel, therefore, that except in cases where the artificial menopause is our objective, and the patient understands thoroughly what this entails, radium treatment should not even be considered except after the failure of all other available types of therapy.

MIGRATORY LABOR IN CALIFORNIA*

By WALTER M. DICKIE, M. D.
San Francisco

DURING the past ten years there has been in California a marked change in the type of casual labor which is employed on the farms and ranches of the state. Before 1927, the majority of the migratory laborers in California were Mexican, with a few Japanese, Italian-Spanish and Portuguese. In about 1928 there began to be a migration of unskilled farm labor from the Middle West to California. These people for the most part

came from the eastern part of Oklahoma, northern part of Arkansas, southern part of Missouri and a few from Mississippi, Alabama, Louisiana and Texas. They are in the main whites of Anglo-American stock whose ancestors have lived for years in the hill area of the south and central United States. In 1935 a close check at the ports of entry to California shows that approximately 53,000 persons who could be classed as indigent or migratory entered the state from the 1st of January to the 1st of July. Of this number 90 per cent were white and about 10 per cent Negro.

An analysis of the reasons for the migration of this type of people to California might not be amiss. We have, first, the reasons for these people leaving their native habitat and, secondly, the need of increasing numbers of casual laborers in California.

These individuals were in their native states "share croppers" who tilled a small piece of land and divided the returns with the owner of that land. In the early part of this decade, the numerous drought seasons decreased the arable land and also the livelihood of many of the people. The amount of yearly return was further decreased by the low price of cotton, which was their main crop, and the policy on the part of the Federal Government for decreasing cotton acreage. During the same era in California, there has been a marked increase in the amount of land in truck farms and cotton acreage. At present, it is estimated that 30 per cent of the large-scale cotton farms of the United States are in California, also 60 per cent of the large-scale truck farms and 60 per cent of the large-scale fruit farms in the United States are in this state. An estimation made in 1935 by the Federal Government shows that the number of casual laborers required is approximately 50,000 in January as a minimum and approximately 200,000 in September as a maximum.

If we look into the ancestry of the majority of these people, we find them of Anglo-American stock whose families have for generations lived in the more retarded areas of the United States, whose customs, education and standard of living are far below the average for this country. We further find that they come from an area where the incidence of the communicable diseases is high, where the sanitation is poor and where the public health activities have been limited. On their migration to California they therefore brought with them a lower standard of living, endemic foci of communicable diseases and a long background of malnutrition.

Such a large group of these persons coming into the state has thrown an added burden on the local charities, the local and county health departments, the state relief agencies and on the State Department of Public Health. It has been felt that two major considerations were necessary: first, the resident population of the state must be protected as far as possible from the communicable diseases such as typhoid, smallpox and malaria that these people might bring with them; secondly, we must, as much as possible, rehabilitate these individuals especially in housing, sanitation and nutrition so

* At several meetings the public health problems involved in migratory labor settlements have been up for discussion in the California State Board of Public Health. At the editor's request, the Director of the Department has submitted the following memoranda on the subject. See also in this issue: Editorial Comment on page 74, a letter on page 131, and press clippings on page 141.

that their children and their children's children who will become future citizens of the state will have equal opportunity for a normal life under the average standards of living.

Early in 1937, the State Department of Public Health, with aid from the Federal Government, began an intensive campaign of immunization against typhoid fever among these migratories. During January, in Madera County, approximately 739 individuals were given three injections of typhoid vaccine at weekly intervals. During February, in Imperial County, approximately 1,000 individuals were similarly immunized. In March, a prospective trainee for the School of Public Health commenced immunization against typhoid fever, and has to date given 17,000 injections. Additional health officers connected with the School of Public Health will be placed in the field during the summer and fall, in order to increase the number of immunizations, as it is necessary that this work be done for our own protection.

There has been, during the past year, an effort on the part of the Federal Resettlement Administration to provide more adequate housing facilities for these migratory people. They have had in operation since January two migratory labor camps, one at Arvin, near Bakersfield, and the other at Marysville. At present they are building four or more camps, which they expect to have completed by the 1st of August. At the request of the Resettlement Administration, the State Department of Public Health made arrangements with the aid of federal funds to place public health nurses in the migratory camps. We have at present one nurse at Arvin who works not only in the established camp of the Resettlement Administration, but also in the squatters' camps of that area. She has done a great deal to instruct and help these people in child hygiene, nutrition, and home nursing care, and aiding in the control of communicable diseases among them. Too much cannot be said of the splendid coöperation that has been given by the county health departments in this work. In the last part of February, another nurse was placed in the Resettlement Administration camp at Marysville. She also has done a most excellent piece of work among these migratory peoples, and has received full coöperation from the health departments.

For the coming year, it is planned to place in the field six public health nurses and two full-time health officers to work among these migratory people. They will act in coöperation with the established county health units in promoting sanitation, adequate housing, nutrition and control of communicable diseases in the Resettlement Administration camps, the grower camps and the casual squatters' camps where these migratory people are found. Immunization for typhoid fever will be continued and immunization for diphtheria will be begun. It is hoped that further help from a nutritionist can be obtained to teach these people to cook balanced meals which will come within their income range.

These people are not residents of the state, or of the county in which they are found, and are,

therefore, not entitled to hospital or medical aid from the counties, so it is necessary in cases of acute illness to prevail upon the counties to admit them for hospitalization, or to call upon the health officer or the private physicians of the community to donate their services. This activity may be considered as an emergency service, for the residence of many of these people is only temporary, and if they remain in California, they will eventually become residents of the state, when there will be no further need for this type of work.

213 State Building.

THE LURE OF MEDICAL HISTORY†

SARRÍA'S TREATISE ON THE CESAREAN OPERATION, 1830*

By SHERBURNE F. COOK, Ph.D.

Berkeley

INTRODUCTION.—The two documents which are here presented as translations afford an insight into a medical problem which at one era in the history of the state attained considerable significance. This problem involved the extraction of fetuses from pregnant mothers when the latter died for various reasons, in order that baptism might be given. What rendered the situation unusually perplexing was that practically no competent medical men, or even midwives, existed who were capable of performing what is here called the cesarean operation. The only individuals with the requisite intelligence and interest in the matter were the missionaries. They encountered the situation mentioned very frequently among their neophytes, the converted Indians, of which there were many thousands. Furthermore, it was also to their interest that the spiritual needs of the white population be properly cared for.

HOW FATHER PREFECT VICENTE FRANCISCO DE SARRÍA MET THE PROBLEM

Thus we find that, during the later days of the missions, the Father Prefect, Vicente Francisco de Sarria,¹ considered the question one worthy of his devoted attention. Although himself by no means versed in medicine, he read what literature he had available, utilized a wide personal experience, and wrote out a treatise on the cesarean operation for the benefit and guidance of his followers. This

†A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of CALIFORNIA AND WESTERN MEDICINE. The column is one of the regular features of the Miscellaneous department, and its page number will be found on the front cover.

*From the Division of Physiology, University of California Medical School, Berkeley.

** In three parts.

¹ Vicente Francisco de Sarria was born in 1767 at San Estévan de Echabarris, near Bilbao, Spain. He entered the Franciscan Order as a young man and came to Mexico in 1804 as a missionary. After serving five years in the College of San Fernando, he came to California in 1809, where he remained until his death in 1835. He served as missionary at San Carlos, 1809-1829, and at Soledad, 1829-1835, where he died at his post. He held the position of Prefect of the Missions, 1813-1819, and again, 1823-1830. From 1823 to 1825 he was also Father President. He is buried at San Antonio Mission. He was generally regarded as one of the best and ablest of the Franciscan missionaries.

treatise, which occupies itself as much with theologic as with strictly medical matters, represents the serious attempt of an intelligent man to contribute to the existing knowledge of his place and time. As such it may be regarded as the first original contribution ever offered by a resident of California in the field of medicine.

FATHER SARRÍA'S LETTER AND TREATISE

It should be noted particularly that the procedure which Father Sarria terms the cesarean operation is not precisely what we today understand by that term. It did not involve the removal of a fetus at full term from a living female—for this could not be done, under church law, by a Catholic clergyman—but rather the extraction of a fetus after the mother had died from other causes. The general method, however, was much the same as with a living subject.

Finally, it may not be amiss to point out that this treatise, together with the introductory letter, not only discusses numerous problems of a theologic, legal, and social nature, but also paints a striking picture of the status of medical theory and practice in California a century ago.

FATHER SARRÍA'S LETTER

"Hail Jesus, Mary and Joseph!"²

To our apostolic fathers and missionaries from the mission of San Carlos to San Francisco Solano:

My very dear Fathers: May Jesus Christ bring you health and peace.

I have never seen any circular or public paper appertaining to our ministry, since by the Grace of the Lord I have been connected with it, which treats of or so much as makes the slightest mention of the cesarean operation.

Nevertheless, an acquaintance with it in many circumstances is important, for the salvation of numerous souls depends upon it as a regular procedure. And since personal and domestic examples are most moving and effective for purposes of persuasion, a single such case may be quoted to illustrate the point. In the work of the Cistercian Monk Antonio Josef Rodriguez,³ entitled *Nuevo Aspecto de Teología Medico Moral*,⁴ where, together with much other material, that illustrious author treats thoroughly and scientifically of the cesarean operation, it may be perceived that one of those who have most advanced this operation in recent times

² This is the covering letter written by Father Sarria to his missionaries. It is dated at La Soledad, July 26, 1850. Both documents, in the original handwriting, are bound together in a small volume in the Bancroft Library, University of California, Berkeley.

³ Antonio José Rodríguez, a Benedictine monk, was born in Mérida, Spain, in 1705 and died in 1781. He was a well-known writer on medical and theological subjects. Aside from the work mentioned here, he wrote various books and pamphlets, including *Disertación Sobre el Gran Problema de la Respiración* (Dissertation Concerning the Great Problem of Respiration).

⁴ Literally: New Aspects of Medico-Moral Theology. This work is not listed in the Library of Congress Catalog, nor is it to be found elsewhere in this country, so far as I am aware, although it is mentioned in the *Manual del Libro Hispano-Americano* by Antonio Palau y Duleit (Barcelona, 1923-7). Any information concerning the present location of a copy would be appreciated by the writer.

with respect to its potentialities for opening the gates of eternal salvation to aborted children, has not only been of our sacred calling, but also has been actively engaged as Apostolic Missionary. This [Cistercian Monk Rodriguez' book] was a result of his observations with reference to the operation during the course of his career as a missionary.

And because it is worthy of some notice on our part I will quote what the above-mentioned author states in this regard [*i. e.*, with regard to the mission problem]:

Volume 4 of the book cited, Paradox 1, marginal number 24:

And in consideration of the same I will add that in the year 1760, when I was soliciting in Madrid the revision and publication of my books, the learned and pious Father Deoclato de Cuneo,⁵ an observant priest, published in Venice a volume concerning the salvation of stillborn and aborted children. Filled with the spirit of charity and love of his fellow men, he asserts that he was moved to write this work concerning the baptism of fetuses and the opening of dead mothers in order to aid the child with baptism, because of the repeated experiences with the loss of innumerable souls, due to neglect of abortion cases, which he knew of and saw in the course of his missionary work.

Thus speaks the illustrious Cistercian. He adds, also, that such having been the impression made upon his soul (to wit, that of the learned missionary of whom he there refers) by this negligence and the care which he believed would constitute the remedy, and in order to anticipate all contingencies, he deliberately studied—as may be seen in his book—everything there is and can guarantee the certainty of his method. In various other parts of his book (*Nuevo Aspecto*, etc.), he quotes with particular respect that good Father and missionary.

And since, speaking of missions, it is not believed even among the faithful that these cases are very rare, permit me to relate here what happened to me in the few trips I made to them [the missions] while I was staying in our Apostolic College⁶ before coming to these missions.

There died a pregnant woman in the locality of the mission where I was staying (it was called Coatepec), to whom I was called, by agreement, to hear her confession, as it seems to me, a short time before her death. She having died and the priest being absent from the district in which we were, the other father (of those of us who were managing the mission) and I, by reason of the obligation under which we perceived ourselves to be in the matter, prepared to do the operation. Not knowing any competent person of whom we might avail ourselves, we took the book which described the operation in order that, while one was reading the appropriate passage and the other executing according to the letter, we might set about the work.

However, there appeared and spoke to us the midwife, a mature woman, who seemed experienced in her profession. She assured us that the

⁵ I can find no trace of this individual. The orthography in the Sarria letter is obscure. The name is spelled both Deoclato and Desclato. He evidently was an Italian, since Cuneo is a province in Piedmont, northern Italy. I also can find no information concerning Hydmo and Tegjos, subsequently mentioned in these documents.

⁶ The Apostolic College of San Fernando, the headquarters of the Franciscan Order in Mexico.

fetus was dead, for a reason or reasons which she gave us, but which I do not remember now. However, we considered them adequate to warrant our believing her and desisting from the operation—and we actually did desist.

If the case were presented to me now, after I have read Father Rodriguez in his above-mentioned book, *Nuevo Aspecto de Teología Medico Moral*, etc., surely I would not hesitate and, while it was within my power, I would take measures to complete the operation.

The said Father Rodriguez quotes the clearest testimony of physicians outstanding in their profession, and even of Protestant authors in support of the thesis that one should not fail to open any woman who dies pregnant, and refers to the instance in which Hyldmo, an excellent surgeon, admits, himself, to have been mistaken. The latter believing the fetus to be dead, nevertheless proceeded with the mother sufficiently to demonstrate that it had died. But actually the fetus was removed alive and did not die until the third day afterward. Thereupon he [Rodriguez] adduces in confirmation another noteworthy example:

But still are his words (on page 26, Volume 4 of the above-mentioned work) even more to the point in elucidating the matter in the case encountered by this same Cangiamila⁷ in October, 1736. A poor woman in his own parish died in a pregnant condition. The midwife, who was of long-standing in her calling, and the surgeon, who was well known and had practiced in the Hospital of the Holy Ghost at Rome, attested and asserted beyond any doubt that the fetus had already died two days prior to its mother. Cangiamila, in nowise disturbed, had the deceased opened and removed a live girl, whom he himself baptized under the name of Placida and who lived a quarter of an hour. The learned and pious Ecclesiastic was desirous of completing fully his triumph. He buried the baby girl with much ceremony, officiating at the interment himself, an action which caused great spiritual joy to the entire city.

Thus speaks the celebrated Cistercian, author of the *Nuevo Aspecto*, etc., a book which, as a matter of fact, is not so very recent, for we saw above, according to his statement, that in the year 60 of the previous century he was making a revision in order to give the work to the press.

The subjoined practical manual (*práctica*) of the cesarean operation is derived almost entirely from what I have seen of this author's description (it contains nothing of my own, save that I have had a copy made of the original draft, which I am enclosing)—that is to say, according to the teaching of the best surgeons and especially Francis Mauriceau,⁸ a French surgeon who practiced the art of obstetrics for forty years in Paris. Monsignor Cangiamila and the above cited Desclato [says Rodriguez] describe it also, but he thinks the method of Mauriceau is to be preferred because of its extensive use.

I hesitate to mention to your reverences the matter of making a copy of this, for I know very

well the difficulties and embarrassments, in addition to other perplexities, which at present beset us in our ministry.⁹ But I would wish, my fathers, considering the object in view, since the situation not only might conceivably arise, but in fact cannot fail to arise in the regular course of events, particularly if the proper measures are taken to ascertain in the case of the demise of all women of the appropriate age and condition, whether or not they are with child, according to the obligation of charity to suffer no soul to perish, and since the remedy is now a standard procedure, clear and easy, such as the one I am giving you—I would wish, I say, that your reverences would make a slight demonstration of the ardor of your zeal and charity for the better discharge of your obligations in this respect by copying, or causing to be copied, the document I am transmitting to you, unless there be already in the mission another one [copy] or perhaps some approved book which treats in detail of the matter and which belongs to the mission. This is in order that practical directions may never be lacking there by which you may be guided whenever it may be necessary or desirable to perform the cesarean section.

Furthermore, it is not sufficient to the purpose that he who is father minister [of a certain mission] at present be acquainted with the operation or be able to perform it without the necessity of further instruction, inasmuch as after him may come some other who, according to the chances of our ministerial destiny, does not know about it.

In order that this copy may be made, as your reverences perceive I particularly recommend, you may retain the circular for eight or ten days and thus take whatever time is convenient to do it. Also, to further the same purpose and in order that the business may not be too long delayed, I myself have had copies made such that one may go from here [Soledad] as far as Santa Barbara, and on the way may circulate the intermediate missions in the regular manner.¹⁰ Another, which is sent directly to San Buenaventura should circulate the missions successively from there to San Diego, and still another at the same time as the former ones through the missions from here to San Francisco Solano.

After having been signed in sequence this letter, with the copy which accompanies it, should be returned from the last mission.

May we remain united in the prayers and holy sacrifices of your reverences, and your beautiful and fervent ministry in the Lord.

Fr. Vicente Francisco de Sarria.

Soledad

July 26, 1830."

(To Be Continued)

⁹ He refers here to the troubles accompanying the secularization of the missions, which was finally completed some three or four years afterward.

¹⁰ The copy of the treatise in the Bancroft Library has inscribed on its title page, "San Antonio Mission," which would indicate that it was the copy which circulated to Santa Barbara. However, the signatures appended to the letter are those from the northern missions as follows: Ramón Abella (San Juan Bautista), Felipe Arroyo de la Cuesta (San Juan Bautista), Juan Moreno (Santa Cruz), José Viader (Santa Clara), Narciso Duran (San José), Tomás Estanega (San Francisco), Juan Amoras (San Rafael), and Buenaventura Fortuni (San Francisco Solano).

⁷ Francisco Manuel Cangiamila, born in 1702 in Palermo, Italy, died in 1763; was Inquisitor-General for the kingdom of Sicily. He was regarded also as a pioneer authority on embryology, having written a work, *Embriologia sacra*, etc.

⁸ Francis Mauriceau was born in Paris (date unknown), and died in 1709. He is described as being an able general practitioner, but is chiefly famous as an obstetrician and gynecologist. He wrote several authoritative works in this field.

CLINICAL NOTES AND CASE REPORTS

PRIMARY RETROPERITONEAL SARCOMA*

By V. BLANCHE SLAGERMAN, M.D.
Los Angeles

REPORT OF CASE

HISTORY.—H. G., a Mexican housewife, age forty-nine, was admitted to the Los Angeles General Hospital, January 15, 1935, complaining of complete urinary retention, accompanied by pain in the bladder region of twenty-four hours' duration. Two years prior to admission the patient had noticed a tumor mass in the lower abdomen approximately seven centimeters in diameter. The tumor gradually increased in size until it reached the umbilicus. She could not remember the date of her first menstrual period, but menstruated regularly every twenty-eight days for three years. The last menstrual period was January 1, 1935. She was married at sixteen and had never become pregnant. Her past history by systems was irrelevant.

Examination.—The patient was an emaciated Mexican female. The pupils were equal and regular, and reacted to light and accommodation. Her teeth were carious. The pharynx was injected. The heart revealed no abnormalities. The lung fields were clear. There was a smooth cystic mass in the abdomen arising from the pelvis to the level of the umbilicus. The pelvic examination revealed a well-supported perineum; the cervix held high under the symphysis; the corpus was anterior and of average size and consistency. There was a fixed tumor mass filling the pelvis and extending to the umbilicus. The lower portion of the mass, which bulged into the cul-de-sac, was firm, while the upper portion was cystic. On catheterization, 1,000 cubic centimeters of urine was obtained.

The laboratory findings were as follows: The blood count revealed: Hemoglobin, 70 per cent; red blood cells, 3,400,000; white blood cells, 8,400, with 68 per cent polymorphonuclears. Urinalysis revealed six to eight white blood cells per H. P. F. The blood Wassermann was four plus.

Course.—A laparotomy was done January 25, 1935. The abdomen was opened by a suprapubic midline incision. The urinary bladder had been displaced upward to the level of the umbilicus. The uterus was of average size and consistency, and was held in an upright position above the rim of the pelvis; its posterior surface was roughened by recently formed adhesions. The tubes were patent and the ovaries were normal in appearance. Retroperitoneal and posterior to the uterus was a mass extending down to the hollow of the sacrum. The exact size of the mass was not obtained because the cystic portion, which contained blood-tinged fluid, was aspirated before removal from the abdomen. The lower portion consisted of a smooth vascular mass measuring 14.5 x 7.5 x 6 centimeters, and was enclosed in a glistening capsule. The central portion of the mass was composed of rather firm white tissue, while the peripheral portion appeared to be cystic, hemorrhagic in character, and much softer in consistency. The microscopic examination revealed a spindle-cell sarcoma.

Postoperatively there was a serosanguinous drainage from the wound for several days, and the patient had a mild pyelitis which cleared under symptomatic treatment. X-ray of the chest on February, 1935, was negative for metastasis. In April, 1935, approximately three months following surgery, x-rays of the chest, long bones and pelvis bones, were negative.

COMMENT

McCallum defines a sarcoma as "a tumor arising from connective tissues and retaining most of

the general characteristics of connective tissues, but endowed with the new power of invading and actively destroying adjacent structures, and of forming colonies of its own in tissues of distant organs." These tumors are classified by the type of cell of which they are composed. The spindle-cell type, which was found in the tumor described above, is one of the more common types of sarcomata. They are composed of spindle-shaped cells very uniform in size and held together in bunches by scanty intercellular tissue and many thin-walled blood vessels. Metastasis occur in the regional lymph glands, but more commonly in the lungs and liver.

As the name denotes, the sarcomata under discussion are found retroperitoneal. The term was first applied by Lobstein in 1829, but included those originating behind the peritoneum foreign to the retroperitoneal organs, and those metastasizing from other organs.

Steele, in 1900, in a classical review of the literature, collected some sixty-one cases, and in 1904, in a second paper, cited thirty-five cases. In 1920, Trout and Meekins added twelve more cases to the list. In 1922, Andrews, in a very scholarly report, added six more cases from the literature, and twenty-eight from the Mayo Clinic. In 1930, P. H. Cook reported a case. With the case reported above, we find the total to be 144.

The etiology of sarcoma, and the retroperitoneal type in particular, is a matter of speculation. The fourth to the sixth decades of life seem to give the greatest number of cases. In the Steele series the youngest individual to present such a tumor was under one year of age and the oldest seventy-eight years. The youngest patient reported by Andrews was two and one-half years of age, the oldest sixty-two years. The incidence is greater in the male than in the female. There are fewer cases reported in the region of the pelvis than any other location.

The more common types of retroperitoneal tumors are the spindle-cell sarcoma and the small round cell, or lymphosarcoma. In the early stages the tumors, which are rarely multiple, are usually firm and lobulated, and later become hemorrhagic and undergo cystic degeneration.

The symptoms of these tumors are indefinite because they grow slowly and, therefore, pass unnoticed until they produce pressure symptoms or involve vital organs. In the pelvis, interference with bladder function seems to be an important symptom, and pressure on nerves and vessels give pain and edema of the legs. The constant signs of retroperitoneal sarcomata are: low-grade fever, loss of weight, secondary anemia, and the presence of the colon in a groove on the anterior surface of the tumor. Because of the indefinite symptoms and the difficulty in differentiating abdominal tumors on examination, the retroperitoneal sarcoma goes undiagnosed in the great majority of cases until surgical intervention. The course of the disease is variable, depending upon the location of the tumor and its rate of growth, which may last from one month to years.

* From the Los Angeles County Hospital.

The treatment of retroperitoneal sarcomata has been mainly surgical, with variable results. Often, because of the location and involvement of vital structures, surgery is difficult and unwise. Radiation was first used in this type of case, and perhaps in connection with surgery will prove a valuable form of treatment. With the advent of modern laboratory and clinical method the mortality and morbidity should be lessened.

IN CONCLUSION

1. Retroperitoneal sarcoma should be added to the differential diagnosis of abdominal tumors.
2. Metastasis occur in 33 per cent of the cases, most frequently to the liver and lungs.
3. Signs of retroperitoneal sarcoma of the pelvis are: disturbance in bladder function, loss of weight, secondary anemia, low-grade fever, and the presence of the colon in a groove on the anterior surface of the tumor.
4. Surgery and radiation are the accepted form of treatment.

1625 West Santa Barbara.

BONE DRILL FOR PINS AND WIRES*

By GORDON MONROE MORRISON, M.D.
San Mateo

SKELETAL traction, using Kirshner wires or Stienman pins, is the method of choice in many fractures. Difficulty is often met in driving or drilling these wires through the tissues. The most common sources of trouble are mechanical in nature, and come from the rotary movement of the wires which very often wind up various soft structures on the wires. This tissue may become so bulky as to prevent the wire from going through the cortex. It is also quite possible that important structures may become avulsed by this motion. After the use of motor-driven or fast mechanical drills, there is often observed in subsequent x-rays so-called ring sequestra, which are due either to wrapping up on the wire of soft tissues, or periosteum or actual cauterization of the bone by the frictional heat.

In introducing the larger pins, especially in femur work, the various keys, hand chucks, etc., although they do not tend to wind up the soft structures, are so inefficient mechanically that



Fig. 2.—Ring sequestra in humerus following use of Kirshner wire with ordinary drill.

much excess time and energy are consumed in introducing these pins.

By making a few changes on a valve-grinding tool, which sells for less than one dollar, we have produced a very efficient and easily operated drill for introducing both pins and wires, which prevents winding up of soft tissues because of the reciprocating movement. It greatly facilitates the introduction of large pins because of the mechanical advantage. It is not possible to run the device fast enough to cause any damage due to frictional heat.

The instrument, as shown in the illustration, is a valve grinder with the shaft hollowed, lengthened to about twelve inches, and a one-fourth-inch chuck placed on the end of the shaft. The pin or wire thus lies within the hollow shaft. The entire apparatus may be sterilized.

Medical Arts Building.

EVIDENCES OF CURE OF GONORRHEA IN THE MALE

By WILLIAM H. RAMBO, M.D.
Los Angeles

THE question of cure and the propriety of marriage in gonorrheis is an ever-recurring one which must be answered by the physician with utmost care, since no little potential suffering and misery depend upon the accuracy of his statements.

Much of the gonorrhea existing today is the result of carelessness in this regard. Pronouncing

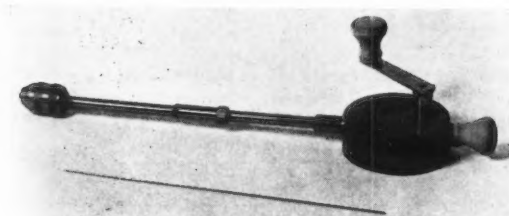


Fig. 1.—Converted valve grinder with hollow shaft, chuck and Kirshner wire.

* From the Orthopedic Service of Dr. E. W. Cleary, San Mateo County Hospital.

a patient "cured" requires a great deal more than a macroscopic study of the urine alone, since a clear urine is very common in patients who are not cured and will not be cured for months.

In determining a cure one should remember that the mucosa of the anterior urethra in a high percentage of men remains sensitized to the gonococcal toxins for months. This constitutes a very good index of cure, since it invariably shows a purulent response to these toxins within a few hours. Consequently, through the emptying of retained gonococcal products into the urethral lumen, we can usually prove, by studying microscopically the resultant discharge, that our patient is not cured, or, if this is insufficient, by considering the centrifuged urinary sediment.

There are various methods by which these areas can be made to empty into the urethra. The small crypts of the urethra are usually emptied of their contents by a massage over a capacity-sized sound, and digital massage is usually sufficient to empty the prostate, the seminal vesicles, and the Cowper's glands. Several such attempts are frequently necessary, since a focus that is not emptied at one time may become so on repetition of this procedure. Should these measures fail to produce macroscopic or microscopic evidences of infections, a provocative alcohol diet may bring about a recurrence.

Every urethra should be carefully examined, for inflamed crypts and urethral glands, through the urethroscope which, in trained hands, is invaluable as a diagnostic instrument. A word of caution, however, seems appropriate, since the novice is prone to use this instrument carelessly, and at a time before the urethral mucosa has healed sufficiently, thus causing an unnecessary acute exacerbation which may prove embarrassing.

Occasionally even these procedures fail on the uncured patient. The infection may remain dormant for months, or until the patient indulges in prolonged sexual excitement or actual coitus, when it often reappears and infects his partner. For this reason he should be warned not to have any sexual relations for at least three months without the use of a condom.

Opinions^{1,2} vary as to the value of the complement-fixation test as a criteria of cure, since some long-standing gonorrheas may never exhibit a positive blood test, and others show a positive blood many months after the case is otherwise negative. In 1932, Price³ introduced a new antigen and improved technique which greatly enhanced the value of this test; however, in my hands it has been a disappointment as a test of cure, but it frequently is of value in diagnosing metastatic gonorrhea and, during treatment, as an indication of efficient drainage. Especially is this test unreliable when vaccine therapy has been employed.

Experience shows that isolation of the gonococcus from the vesiculoprosthetic fluid by cultural methods in these apparently cured cases is one of the most difficult of laboratory procedures. However, I have been successful in isolating the gonococcus in many clinically cured cases by using

hydrocele dextrose agar as a media, and employing the oxidase reaction described by Gordon and McCleod,⁴ and more recently by Carpenter and Leahy,⁵ to identify the Neisserian group on the culture surface. These colonies are then picked off with a platinum loop, spread, and stained by Gram's method. A careful microscopic examination is necessary, since all members of the Neisserian group give a positive oxidase reaction, and false positives are given by a thin filiform type of *B. coli* and *B. subtilis*. This test is rapidly gaining favor as a criterion of cure, since it is accurate in more than 90 per cent of the known cases thus examined.

In evaluating this test, one must remember that one negative is never sufficient and cannot be accepted as a criterion of cure, notwithstanding negative clinical observations and negative pathologic and bacteriologic tests. I consider this test of sufficient importance to repeat it at monthly intervals, until three consecutive negative cultures have been obtained during the period of observation following treatment. A positive growth is definite evidence against cure.

SUMMARY

1. A complete absence of purulent urethral discharge and a urine containing no evidence of infection are insufficient evidences of cure.
2. Negative microscopic spreads from the urethral mucous, prostatic secretion, seminal fluids, and urinary sediments are important presumptive tests.
3. Negative macroscopic and microscopic findings following repeated efforts to create discharge by the passage of sounds and massaging upon them, and digital massage of the prostate, seminal vesicles, and the Cowper's glands suggest probable cure.
4. Negative urethroscopic findings are essential to cure.
5. A provocative alcohol diet and sexual indulgence are of definite value as a preliminary to the final tests.
6. The complement-fixation test yields good evidence of efficient treatment, but not necessarily of cure.
7. The inability to isolate the gonococcus by cultural methods at monthly intervals, together with negative clinical findings, are strong evidences of cure.

523 West Sixth Street.

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BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

ERYSIPELAS

I. SYMPTOMS

FRED H. KRUSE, M.D. (384 Post Street, San Francisco).—Like all other infections, the primary effects of erysipelas include the local symptoms referable to the focal invasion and the general or constitutional reaction. The secondary effects, and therefore the complicating symptomatology, result from the spread of the streptococcal infection into other organs such as the joints, kidneys, or central nervous system.

Erysipelas is a violent inflammation of the superficial lymph channels, and occurs most frequently about the face and head, probably because of the excessive number of superficial lymphatic vessels in these regions. This is characterized by a disseminated inflammation of the skin. Tension of the cellular tissues becomes very marked, and as the inflammation advances, a sharp line of demarcation is usually noted at its edge, clearly distinguishing the swollen, raised and reddish area involved from that of the adjacent, normal skin. Blebs may form on the surface from the intense irritation of the papillary layer of the skin. When the deeper lymphatics are affected, a great deal of effusion takes place in the cellular tissue, and cellulitis results.

There may be a wound or break in the skin from which the redness starts, or there may be no cutaneous evidence of the seat of the infection. A fissure in the skin at the opening of the nares, especially associated with a recent cold, is a most frequent start for erysipelas of the face. The inflammation may extend to the fauces or tongue, or proceed painlessly up the eustachian tube, involve one or both eyes, and even cause blindness. The delicate skin of old people, slightly traumatized, eczematous lesions, trivial scratches or abrasions anywhere, may be the site of ingress of the offending streptococcus. There may be red streaks showing lymphatic channels extending from a wound to the point of acute inflammation, or, having traveled up the lymphatics, the organism may start the erysipelatous process at a distance from the seat of entrance. The local area involved is tense, hot and painful, and very tender to touch. With the onset of the disease, fever develops, and may rise to 104 degrees Fahrenheit or even higher. This is frequently preceded by a chill. Intense malaise, accompanied by muscular pains and prostration, with headache, rapid pulse, sweating, and dehydration may follow. On the other hand, fever may not be excessive, depending upon the dissemination of the infection. It may be a continuous, remittent or intermittent type. Occasionally no fever occurs, usually when

the immunizing functions are inadequate, and some of these cases may be very grave.

A high white-blood count, with increased polymorphonucleated cells, is generally found, the leukocytosis varying with the degree of fever. In about one-third of cases of severe erysipelas the blood culture is positive for streptococcus, but this does not necessarily imply an unfavorable prognosis.

The usual gastro-intestinal symptoms of an intense infection develop, with varying degrees of nausea, vomiting, thirst, anorexia, and a badly coated tongue.

The urine is concentrated, highly colored, and albuminuria may be considerable. Bile pigment, red blood cells, and casts may be found.

The spleen may be palpable, and lumbar pain is frequent.

Sore throat, tonsillitis, tracheitis, and even pneumonia may ensue.

There are many very mild cases of erysipelas lasting only a day or two, but usually the disease delineates its course in two or three weeks. The duration is uncertain, however, and often it subsides only to reappear again, traveling over the whole body and even attacking the same locality again.

Like chronic recurring herpes simplex, erysipelas may habitually reattack the same individual many times, most frequently about the face, from a chronic nasal focus.

The secondary effects or complications include not only those I have named about the head, throat, and eyes, but the streptococcus may localize in the lungs, producing pneumonia and empyema; the kidneys in 38 to 40 per cent of cases causing a nephritis; the heart, resulting in myocarditis and endocarditis, and in the joints as a synovitis or suppurative arthritis. Meningitis and mastoiditis are not uncommon. In fact, no system or organ of the body may escape the ravages of this form of streptococcus infection.

* * *

II. ETIOLOGY AND DIAGNOSIS

R. MANNING CLARKE, M.D. (1219 Hollingsworth Building, Los Angeles).—Erysipelas has been known from the remotest antiquity. It is clear from the writings of Hippocrates that it was known long before his time. Hippocrates, Galen, and Celsius, all three wrote extensively regarding it. They all distinguished the traumatic from the idiopathic, and gave very good descriptions of the condition clinically.

The ideas of these ancient writers on the subject of its etiology are most interesting. They recog-

nized its seasonal occurrence in spring and fall. From this they drew the conclusion that "there were certain poisons" in the air of certain weather conditions that caused the disease. It was clearly recognized that those living in bad, uncleanly conditions were especially prone to suffer from the malady. Whether or not it was because of these two conditions, *c. g.*, the weather and unsanitary surroundings, cannot be said; but one gets the inference that they felt there was some earthy influence with which they had to deal. All writings of this time are full of talk about telluric influences. Tollus, the Roman god of the earth, was accredited by many lesser writers with the power to influence this disease.

Galen lay great stress upon certain biliary changes which influenced the blood and was thereby a specific cause of the disease. "Poisons of the bile," circulating in the blood, were put forward by many writers, following him, as the most probable cause of the disease. This idea really held forth until the end of the eighteenth century. At this time in England (1777), John Hunter and Gregory suggested that the nature of the disease might be parasitical. Velpeau and Trousseau in France began at once to support this idea, with the result that the old explanations began to weaken. Wernher, Billroth, Volkmann, and many others, soon endorsed the new teachings.

Nepveau was the first to discover organisms in the lesion of erysipelas in 1870. Lukomsky (1874) then showed that the organisms were in the lymph spaces, and not in the blood vessels. Nothing of any account happened after this until Fehleisen (1882) discovered a coccus that occurred in long chains in the lymph spaces. He worked constantly with this organism and shortly thereafter he was able to grow it in pure culture. He named it *Streptococcus erysipelatus*. With this organism, Fehleisen was able to produce the disease in both rabbits and humans under classical conditions, and felt the ultimate answer had been provided.

Von Jochmann, Widal, and others, soon objected to the finality of the conclusions regarding this, and suggested that erysipelas could be produced by any streptococcus taken from a case of peritonitis, for instance. . . . It is now generally accepted that erysipelas is caused by a streptococcus belonging to the beta group; that is, streptococcus hemolyticus. However, Gay, in his celebrated recent text, says: "Howell, Tunnicliff, and Birkhaug, all came to the conclusion that erysipelas cocci belong to the single antigenic group in contrast to hemolytic varieties from all other sources. Birkhaug has extended his conception by means of interactions between the toxin of erysipelas strain and a corresponding antitoxin. Schwartzman offered another criterion of differentiation in his assertion that erysipelas strains are specifically susceptible to a particular streptococcus bacteriophage. Subsequent work by Singer and Caplan, by Okell and Parish, and by Williams, based also on toxin antitoxin experiments, led them to the directly opposite conclusion, namely, that the streptococcus of erysipelas does

not possess strict biologic specificity, with which we should agree until further information is available."

Secondary Etiology.—Temperature and climate have quite a direct influence. The disease occurs almost entirely in the temperate zone. Its seasonal variation has always been noted. Cold months of spring and fall are apt to cause an increase. April, I believe, heads the list of all months.

Uncleanly habits, failure to observe the fundamentals of personal hygiene are important. Unsanitary conditions, especially in plumbing and housing, poor ventilation, and overcrowding, can usually be depended upon to bring about epidemics or outbreaks. This is true in families, but still more so in barracks or institutions.

Lowered individual resistance is a direct invitation to the disease. It may be either local or general. Trauma of any kind, whether gross or microscopical, is an important factor. Alcoholism, malnutrition, excessive childbirth, the parturition period, nephritis, carcinoma, and other factors too numerous to mention, are well understood in their influence over erysipelas.

The diagnosis of erysipelas after the presenting skin lesion is relatively easy. It is in those patients in whom the prodromal symptoms are of long duration, or where the skin manifestation occurs in an atypical form or site that diagnosis becomes difficult. For the most part, there are only a few conditions which offer differential diagnostic possibilities.

It is essential to have the chief diagnostic features of erysipelas in mind before attempting a differential diagnosis. We must remember that erysipelas may be any gradation from a relatively benign ambulatory condition to an extremely toxic one, resulting in a fatal termination, depending upon the virulence of the organism, the resistance of the host, and the part affected. It is unusual that a truly acute erysipelas does not have the usual prodromal symptoms of malaise, nausea, chills (with fever ranging from 102 to 107), depression and severe headache. This is followed in twenty-four to seventy-two hours by the rather small, sharply circumscribed, edematous, shiny, bright red, dermal manifestation. This spreads rapidly, even involving the mucous membrane, usually stopping at the hair margin unless of virulent character. When the hair or beard is involved, there is usually a resultant temporary alopecia. The area seldom becomes larger than palm-sized, but may involve an entire extremity or even, in some fatal cases, the entire integument. When the eruption develops rapidly, and severe edema is present, vesicles or bullae appear superimposed upon the above lesions.

It is quite common to have erysipelas follow insignificant operations, such as pricking the ear for blood, incising a pustule, or even vaccination, as well as more serious operations such as sinuses, episiotomy, appendix, and mastoid.

The acute dermatitis venenata with severe edema and superimposed bullae will oftentimes

assume a rather sharp demarcation, particularly in cases of occupational etiology such as plant or chemical allergies. In these cases the lack of constitutional symptoms and the suggestive history, plus the positive contact or patch test, are sufficient for diagnosis.

The chronic circumscribed eczemas or lichen chronicus simplex cases are of relatively long duration and, although sharply marginated and deeply infiltrated, are usually lichenified and covered with an adherent whitish scale in contradistinction to the bright red, shiny, edematous and oftentimes bullous erysipelas lesion. Acute infectious exanthema exhibit the coalesced erythematous papulo-vesicular puncta, which tend to be more generalized and results from toxic absorption rather than infection with the streptococcus.

In streptococcal septicemia, many times areas of typical erysipelas will appear during the course of the disease which often results fatally.

Occasionally lupus erythematosus assumes an acute form which frequently affects the cheeks, eyelids, nose, ears, and mouth, causing a rather sharply demarcated erythematous, edematous, occasionally bullous eruption quite consistent with an acute erysipelas. It usually affects the hands or some other part of the body, and does not have the severe constitutional symptoms.

The simple erythema multiforme, may occasionally be confused with erysipelas, but should not be for long. The multiplicity of lesions and their tendency to remain *in situ* without extension, as well as much less severe prodromal and systemic symptoms, rule this condition out.

Lastly, one must consider the entity described by Rosenbach as erysipeloid, in which he refers to those cases caused by trauma, and particularly fish or crab trauma. The eruption consists of a migratory, sharply marginated violaceous eruption which usually has no systemic symptoms. It is thought that it is caused by a fungus or "ring-worm" infection. Streptococci are rarely found.

Erysipelas is a condition which requires considerable ingenuity at times, both in diagnosis and in treatment.

* * *

III. TREATMENT

EDWARD B. SHAW, M.D. (384 Post Street, San Francisco).—The course of erysipelas is extremely variable without respect to the treatment employed. Rapid regression often occurs spontaneously, sometimes encouraging optimism concerning whatever therapy may have been employed; but no less frequently is this optimism dashed by immediate recurrence in the case in question, or by a complete absence of comparative therapeutic effect in other cases. It can only be said that this disease is unsatisfactory to treat, and that the very diversity of methods of treatment in common use merely emphasizes the inadequacy of any one as a specific curative agent.

Nor is the therapy notably simplified by proof that the streptococcus is the etiologic agent. This

naturally suggests the use of agents designed to stimulate the active production of immune bodies by the patient, or to supply these substances to him by means of human or animal immune serum. The greatest deterrent, from an immunologic standpoint, to this type of reasoning is that the patient, at the height of his disease and in the face of exacerbation and extension, may be highly "immune" according to laboratory standards, although nonetheless clinically unable to arrest extension of his disease. Streptococcus vaccines are usually regarded as of no clinical utility, and ordinary polyvalent streptococcus serums are but seldom employed. The most recently developed agent of this sort is an antitoxin, prepared by the immunization of animals against the specific toxin of the erysipelas streptococcus by a method similar to that used for the preparation of scarlet fever antitoxin. The utility of this antitoxin is uncertain; although some observers express the opinion that it is clinically useful, others feel that evidences of its value fail to take sufficiently into account spontaneous variations of the disease or the occasional beneficial effect of the injection of any protein material. The action of the antitoxin is in decided contrast to other diseases, such as diphtheria and scarlet fever, in which antitoxins are used with decidedly beneficial effect. Erysipelas will continue to extend after the administration of large amounts of antitoxin. In the face of slender evidence of the specific virtues of antitoxin, the clinician must weigh its benefits against the probability of production of unpleasant reactions to horse serum. A good many competent observers presently reserve antitoxin for occasional use in less favorable cases, and especially employ it in infancy where the prognosis is poor, the likelihood of serum reactions is small, and the beneficial effect of nonspecific protein therapy is sometimes suggestively of value.

Human convalescent serum has been employed to some extent, but results have proved in disappointing contrast to those secured in scarlet fever and certain other infections treated with convalescent serum. One cannot, of course, discount the important supportive effect of transfusion in any severe disease, and transfusion of the patient from a recent convalescent supplies not only this general effect, but adds to it the possible benefit of specific immune substances and immune blood cells.

Purely nonspecific shock therapy is not altogether to be despised; some observers still favor the use of such agents as leukocytic extracts and various other protein materials. Improvement after this type of therapy is not altogether unconvincing, but is not easily explicable. A comparatively recently developed agent for use in many types of streptococcus disease is prontosil, which is an effort at chemotherapy of these infections. This drug has been employed in erysipelas with results that are not completely disappointing. In view of the excellent experimental background of prontosil, and the poor effects of all forms of treatment in erysipelas, this agent

should be more thoroughly tried in an effort to reach final opinion. Toxic effects of the drug are apparently minimal.

Apart from measures designed for direct effect upon the etiologic streptococcus, certain forms of local treatment remain to be mentioned. The chief of these is roentgen therapy. It is difficult to state the precise manner of action of x-ray in the treatment of erysipelas: it may have some direct effect on the invading streptococcus, a stimulating effect on the local tissues, or an entirely nonspecific effect which it produces by means of protein split products. At all events, x-ray undoubtedly deserves to be placed first among the therapeutic agents at present employed in this disease. The dosage and frequency of application of therapy demand the judgment of an experienced roentgenologist. The results of treatment are frequently so prompt and striking as to leave no doubt of its usefulness. Other forms of radiation, especially ultraviolet radiation, have been employed to some extent, but are far less dependable and convincing than is the x-ray.

A variety of local applications have been applied to the lesions of erysipelas, but their effects must largely be judged by the amount of comfort they afford the patient. Especially if the disease arises from an open lesion of the skin, compressing is indicated in an effort to encourage drainage outward from the lesion. When the process is extending over the unbroken skin, it is permissible to apply almost any form of compress which produces comfort. Many patients prefer cold compresses of magnesium sulphate, boric acid, dilute aluminum acetate, etc., while others seem to derive more comfort from hot compresses. Most patients dislike the application of ichthyol or other greasy applications, and the evidence of beneficial effect from these is not convincing. The one who prefers no local treatment at all receives the sympathetic coöperation of the writer. An ingenious suggestion consists of surrounding circumscribed lesions by a line painted with collodion. The collodion, in drying, constricts the superficial lymphatics and impedes the spread of the disease, although not acting as a complete deterrent to its spread. Nothing is lost by this method if the disease is well localized, especially to an extremity, and the spread of infection, and perhaps the absorption of toxin, are in a measure slowed.

Patients with erysipelas may be ill to varying degrees. Their care usually calls for conscientious supervision and careful nursing, adequate attention to nutrition, fluid intake, and elimination. Local measures should be selected with regard to the patient's comfort. X-ray therapy should be instituted early, and may be repeatedly administered by a competent radiologist. The use of pron-tosil for specific chemotherapy deserves extended but experimental trial, and promises to be useful. Erysipelas antitoxin is not of great value, but may be tried in infancy or with the aged or others where the prognosis is poor.

Farm Population Reduced Slightly During 1936.—A farm population of 31,729,000 persons as of January 1, 1937, was estimated today by the Bureau of Agricultural Economics, compared with 31,809,000 on January 1, 1936. The net loss of eighty thousand persons represents the first decrease in farm population since 1929.

The bureau reported that 1,166,000 persons left farms last year, and that 719,000 moved to farms from villages, towns, and cities. But the net migration off the farms was almost entirely offset by an excess of farm births over deaths: Births were estimated at 716,000, deaths at 349,000.

The number of births on farms last year was the smallest, and the number of deaths the largest, in fifteen years of bureau records. The number of persons moving to farms was the second smallest during this period, and the number of persons moving off farms also was the second smallest.

The bureau said that "with a decrease in farm population there is a reversal of the trend observed during the years 1930-35, when farm population increased every year. Since 1910 there have been several periods when the farm population reported decreases. From 1910 to 1918 there was a decrease which became pronounced during the World War. Following the war, farm population increased until 1921.

"Farm population decreased between 1922 and 1929, and at the beginning of 1930 there were fewer people on farms than there had been at any time since the World War. From 1930 to 1936 farm population increased somewhat. During the past four years the number of people on farms has remained nearly constant, changing by less than 100,000 each year."

The figures reveal that the farm population now is little less than the peak figure of 32,076,960 persons reported for 1910, but much larger than the low of 30,169,000 persons reported for 1930. The bureau said that "the result of all the changes of the past twenty-seven years is that the farm population today is about 1 per cent less than in 1910."

Although the number of persons in the United States has increased by nearly 40 per cent since 1910, the number of persons living on farms today is slightly less than it was in that year. Since 1920, however, more people have moved from farms than to farms during every year except 1932.

The bureau pointed out that the increase in farm population between 1930 and 1935 was due more to the fact that fewer people were moving to towns and cities than to any great "back-to-the-land movement." But with the resumption of urban employment opportunities in recent years, there has been an increase in net migration from farms.

Although the net change in farm population total was slight last year, the bureau reported "pronounced changes in some of the major geographical divisions. In the West North Central and West South Central States, where the drought of 1936 was particularly severe, the decreases reported during 1934 and 1935 were continued during 1936.

"As a result of its losses, the West North Central Division on January 1 this year had fewer people on farms than in 1930. In the other geographic divisions the number of people on farms was greater than in 1930, but in the West South Central and Mountain States the differences were small. If there are further decreases during 1937, farm population in the latter regions will drop below the 1930 level. A number of states in these regions already have fewer people on farms than they had in 1930."

During 1936 there were decreases in the Mountain States, although the fact that the western portion, including Idaho and Arizona, was receiving migrants from the drought states to the east, kept the losses of the entire region at a relatively small figure.

The Middle Atlantic States, including New York, New Jersey, and Pennsylvania, also reported a decrease in farm population, as did the industrialized states of the East North Central group. In both cases the losses were due largely to migration from farms to towns and cities. In the South Atlantic and East South Central States farm population increased primarily because there were many more births than deaths in these states. Farm population in New England remained unchanged.

The patient comes to the physician for advice, consolation, and hope. If he gives none of these, he may be an excellent diagnostician and prognosticator, but he fails somewhat as a physician.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION

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THIS MONTH'S TOPICS*

ASSOCIATION ACTIVITIES

1. *Amended Principles of Ethics.*
2. *Endowment Fund.*
3. *Further Comment on American Medical Association Meeting.*
4. *Passing Comments.*
5. *Abstract Executive Committee Minutes July 10, 1937.*
6. *Bouquets.*

DEPARTMENT OF PUBLIC RELATIONS

1. *When Doctors Disagree.*
2. *Forestry Medical Service.*

ASSOCIATION ACTIVITIES

AMENDED PRINCIPLES OF ETHICS

Chapter III, Article 6, of the Principles of Ethics were amended at this American Medical Association session by the addition of the following paragraph.

"The phrase 'free choice of physician' as applied to contract practice, is defined to mean that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patient and physician when no third party has a valid interest or intervenes. The interjection of a third party who has a valid interest or who intervenes does not *per se* cause a contract to be unethical. A 'valid interest' is one whereby law or necessity, a third party is legally responsible either for cost of care or for indemnity. 'Intervention' is the voluntary assumption of partial or full financial responsibility for medical care. Intervention shall not proscribe endeavor by component or constituent medical societies to maintain high quality of services rendered by members serving under approved sickness service agreements between such societies and governmental boards or bureaus and approved by the respective societies."

It is hoped that some day the Judicial Council will write an explanatory comment upon this section in order to clarify its application.

ENDOWMENT FUND

It is learned through the *Texas State Medical Journal* that the Texas Medical Association is the recipient of a \$50,000 contribution to its endowment fund from one of its members. New York, Pennsylvania, Massachusetts, Colorado, and a few other states are possessed of funds derived from members and lay individuals. California has but one bequest—the Herzstein Fund.

In previous issues it has been pointed out that our Association should have an Endowment Fund Reserve of many thousand dollars. The interest earnings would enable the Association to expand its activities and serve its members in greater degree and greater effectiveness.

* All articles listed under the caption, "This Month's Topics," have been written and sent to the Editor by the Association Secretary, Dr. Frederick C. Warnshuis.

Contributions have been suggested and solicited without results. The tendering of such contributions, the principal to remain intact in perpetuity, serves to establish a lasting memorial and in addition provides for further reaching Association work. In consideration of these benefits, you, member, are again urged to reflect and determine whether your financial position will justify you to tender a substantial subscription. Please help in creating a satisfactory Association Endowment Fund.

FURTHER COMMENT ON A. M. A. MEETING

In the July issue preliminary comment was made upon the Atlantic City meeting of the American Medical Association. It is hoped that every member has read the official minutes as published in the *National Journal*. If not, you are urged to familiarize yourself with these important and far-reaching actions. It is deemed advisable to stress certain major actions in this comment.

Fellowship.—Comment was made as to the desirability of members becoming Fellows. This is of particular interest to California members. Only those who are Fellows can register and participate in the annual session. As the 1938 session is to be held in San Francisco, our members are urged to apply for fellowship affiliation in order that they may attend the 1938 session.

Hospital Staffs.—By resolution the action recorded in 1934 was re-affirmed requiring that approved hospitals limit their staffs to members in good standing in county hospitals.

Hospital Services Defined.—By resolution hospital services under group hospital insurance was specifically defined as being, "limited to the room, bed, board, and nursing facilities ordinarily provided by hospitals, routine drugs and the routine services of internes only when acting under the direction of the attending physician."

"Except as stated above the contract should not include the services of physicians either general or special. The term physician shall be understood to include all licensed practitioners holding the degree of doctor of medicine and all others who assume on their own account to interpret laboratory findings in terms of disease and diagnosis or to administer or direct treatment." This action gives national endorsement to the action recorded by the California Medical Association upon this question.

Federal Medical Services.—In view of the press and other comments made upon the New York resolution it is deemed quite important that members be acquainted with the final action recorded in the following report:

THE REPORT OF REFERENCE COMMITTEE ON EXECUTIVE SESSION

The Reference Committee has carefully considered the resolutions introduced by the New York delegation and has held hearings at which the details of the principles and proposals were freely discussed.

The Board of Trustees has already reported to this House of Delegates its considered opinion pertaining to the reorganization, in one consolidated department, of the activities of the Federal Government having to do with the promotion of health and the prevention of diseases. Copies of this statement, as printed in *The Journal* and in the Handbook of the House of Delegates, page 107, were transmitted to the President of the United States and to others in official position in Washington, and the attention of constituent state medical associations was especially called to the action of the Board:

"Recognizing that committees of the Senate and of the House of Representatives of the United States Government and a special committee appointed by the President are at this time concerning themselves with the reorganization of government activities with a view to greater efficiency and economy, and recognizing also that the President, in his

opening address to Congress, indicated that he would shortly present to the Congress recommendations for such reorganization of governmental activities in the executive branches, and recognizing moreover the great desirability that all activities of the Federal Government having to do with the promotion of health and the prevention of disease might with advantage be consolidated in one department and under one head, the Board of Trustees of the American Medical Association would recommend that such health activities as now exist be so consolidated in a single department which would not, however, be subservient to any charitable, conservatory or other governmental interest. It has been repeatedly said that public work is the first problem of the state. It is the opinion of the Board of Trustees that health activities of the government, except those concerned with the military establishments, should not be subservient to any other departmental interests. This organization and consolidation of medical departments need not under present circumstances involve any expansion or extension of governmental health activities but should serve actually to consolidate and thus to eliminate such duplications as exist. It is also the view of the Board of Trustees that the supervision and direction of such medical or health department should be in the hands of a competently trained physician, experienced in executive administration."

Since the House of Delegates during this session has already approved this action of the Board of Trustees your Reference Committee deems it unnecessary to submit for your consideration that portion of resolutions which deals with this subject.

Your Reference Committee recognizes that certain principles stated in the resolutions presented by the New York delegation have been considered by the House of Delegates on previous occasions and are matters of record. These include, for example, the recognition of the primary importance of public health, the opposition to compulsory sickness insurance, and the separation of the problem of economic need and the distribution of medical service.

The extension of medical service to the indigent has been given careful consideration by the Board of Trustees as reported on page 108 of the Handbook of the House of Delegates, 1937, and was approved by this House during its session June 8, 1937:

"In the past, the medical profession has always been willing to give of its utmost for the care of those unable to pay. The available evidence indicates that today throughout the United States the indigent are being given a high quality of medical care and medical service. Nevertheless, the advances of medical science have created situations in which a group of the population neither wholly indigent nor competent financially find themselves under some circumstances unable to meet the costs of unusual medical procedures. The Board of Trustees of the American Medical Association points out the willingness of the medical profession to do its utmost today, as in the past, to provide adequate medical service for all those unable to pay either in whole or in part. Members of the medical profession, locally and in the various states, are ready and willing to consider with other agencies ways and means of meeting the problems of providing medical service and diagnostic laboratory facilities for all requiring such service and not able to meet the full cost thereof. These are problems for local and state consideration primarily rather than problems of federal responsibility. The willingness of the medical profession to adjust its services so as to provide adequate medical care for all the people does not constitute in any sense of the word an endorsement of health insurance, either voluntary or compulsory, as a means of meeting the situation."

The American Medical Association is cognizant of the medical needs of the people of the United States; it is genuinely interested in all plans for providing and distributing medical care. The records, reports, source material, and experience of the Association are of great value. They are at the service of agencies contemplating the development and operation of plans for medical care. These factual data, source material, and experience are readily available for use in promoting and protecting the health of the American people.

Your reference committee recommends that the bureaus, councils, and committees of the Association continue their studies of the need for and the methods of distributing medical care to the end that the American Medical Association shall continue to do everything possible to promote and protect the health of the American people.

The American Medical Association reaffirms its willingness, on receipt of direct request, to cooperate with any governmental or other qualified agency, and to make available the information, observations and results of investigation together with any facilities of the Association.

THOMAS MCGOLDRICK, New York
J. H. CANNON, South Carolina
E. H. CARY, Texas
E. F. CODY, Massachusetts
JOHN H. FITZGIBBON, Oregon.

Senator J. Hamilton Lewis address.—This address is published in full on page 2,221 of the June 26 issue of the *Journal of the American Medical Association*. In the light of subsequent events and investigations it is difficult to appraise the Senator's statements or to indicate just what is being proposed and promoted by certain parties active in the national capitol. The remarks may well be pondered over. American Medical Association officials are maintaining close contact and vigilance.

PASSING COMMENTS

There is a potential reservoir of medical knowledge and service in every community which can be actuated to serve public health needs.—Vaughan.

* * *

Under the caption of "Doorstep Baby," the editor of the *Indiana State Medical Journal* fixes the parentage of a certain quest that was sought to be attained at the recent American Medical Association meeting.

* * *

Maryland and Florida State Medical organizations have gone on record as firm opponents to the suggestions made by Senator J. Hamilton Lewis.

* * *

If you are not a *Fellow* of the American Medical Association, it is suggested that you apply for Fellowship in order that you may register and attend the 1938 meeting in San Francisco. Only Fellows may register and obtain a badge. Badge must be shown to gain admission to all meetings and exhibits. Do not confuse membership with fellowship. If you are paying subscription and receiving the *Journal* of the American Medical Association be sure and ascertain if you have ever applied for Fellowship and have a Fellowship card. That card is necessary to register.

* * *

The Sixty-seventh Annual Session of the California Medical Association will be held in the Huntington Hotel in Pasadena, May 9-12, 1938.

* * *

Announcement will be made in the next issue of the program, that will govern the annual conference of county secretaries, standing committees, officers and councilors to be held in October.

* * *

Wanted! Five hundred members to send in \$100 each to create the initial fund for an Association Endowment Fund. The Fund will be kept intact in perpetuity. The earnings will be used to expand Association work. Will you send your contribution this month?

* * *

Elsewhere in this issue there will be found a list of bills passed at the last Legislature, of medical and health interest that died by reason of the Governor's failure to sign them.

* * *

Time spent in well planned post-graduate work produces dividends in increased income. You will do well to arrange to spend this time at one or more of the post-graduate courses offered by our medical colleges.

* * *

If you wish to present a paper at the Pasadena meeting write to the Section Secretary applying for a place. Send topic and a brief résumé.

* * *

When in San Francisco drop in at your Association's headquarters. You will be most welcome and it will be a pleasure to extend to you every possible assistance. This is a personal invitation to every member.

* * *

A copy of each issue of our official journal is being sent to the officers and delegates of the American Medical Association. This is for the purpose of acquainting those who represent sister states with the work and problems of this Association.

* * *

What are you doing to gain public favor and good will for scientific medicine and its practitioners?

ABSTRACT EXECUTIVE COMMITTEE MINUTES.
JULY 10, 1937

1. Executive Committee of Council met in San Francisco at 9:00 a. m., July 10, 1937. Present: Doctors Schaupp, Morrow, Roblee, Pallette, Dukes, Kress, Secretary Warnshuis, Counsel Peart. Absent Doctors Gibbons and Goin.

2. Annual meeting date.—The date for the 1938 Annual Session in Pasadena was fixed as May 9-12.

3. Draft for the program for the October Conference of County Secretaries, Standing Committees, Officers, and Councilors was approved.

4. In accordance with an established policy, the endorsement requested of the objects, purposes, and organization of the American Society for the Control of Venereal Diseases was withheld.

5. Medico-Economic Survey.—A detailed discussion was had on plans, ways, and means for the publication and distribution of the final report on the Medico-Economic Survey. Plans for publication were approved. Sufficient copies will be printed to supply one copy for each Association member and for Federal and State representatives and desired copies requested by the Projects Director of the Works Progress Administration, Dr. J. B. Sharp.

6. Secretary was directed to secure and file in the Association office the files and records of the Committee of Five.

7. Adjourned at 1:15 p. m.

F. C. WARNSHUIS, *Secretary.*

BOUQUETS

Sometimes it is advisable to impart what others say about you and to record their appraisals. *CALIFORNIA AND WESTERN MEDICINE* is being sent to the members of the American Medical Association House of Delegates. The following are extracts of letters of acknowledgment:

"I have greatly appreciated the courtesy of the California Medical Association in sending me regularly its official publication. I have enjoyed it greatly and have profited by reading it. I appreciate being continued on the mailing list.—Hilton S. Read, Chairman of Welfare Committee, The Medical Society of New Jersey."

"I think you have a splendid publication. It has given me a better insight into the problems of medicine in the western section of the United States. I am very glad to know that I am to be continued on your mailing list. With every good wish for the continued success of your Association and to you personally, as Secretary, I am with kindest regards, J. Allen Jackson, Superintendent, Danville State Hospital, Danville, Pennsylvania."

"Many thanks for your letter of July 1. I read your *Journal* when it comes with pleasure and profit and am grateful.—Frederic E. Sondern, Past President New York State Association."

"In thanking you and through you the Council for this courtesy, may I take this opportunity of saying that *CALIFORNIA AND WESTERN MEDICINE* has been read during the past two years with continued interest in its scientific subject matter and with an increased understanding of the problems and policies of the California Medical Association.—Virgil E. Simpson, Louisville, Kentucky."

"I enjoy and am interested in reading *CALIFORNIA AND WESTERN MEDICINE* and thank the Council for continuing my name on the mailing list.—Olin H. Weaver, Macon, Georgia."

"Many thanks for your letter of July 1 regarding the distribution of your publication, *CALIFORNIA AND WESTERN MEDICINE*. We enjoy your publication very much indeed,

and certainly appreciate being kept on your mailing list.—Stanley H. Osborn, State Department of Health, Hartford, Connecticut."

"This is a very fine publication, and its statement respecting our mutual problems in the field of medical economics are of particular value to the Board of Trustees.—Ralph A. Fenton, Trustee, American Medical Association."

"I have enjoyed reading *CALIFORNIA AND WESTERN MEDICINE* very much. Further more, as soon as I finish with it the magazine is placed in the reading room of the internes at the Springfield Hospital, where I know it is used to good advantage.—John M. Birnie, Springfield, Massachusetts."

"I have pleased and profited by reading the scientific articles and your legislative problems and programs. I have fancied that you have had all and more of the problems of medicine than have any of the other states in the Union and hence feel that getting your reports, I have gotten all the others. The scientific articles are certainly equal to any state journal which I have known and I shall be pleased to receive it for another year.—C. C. Mechling, Pittsburgh, Pennsylvania."

"I beg to acknowledge your letter of July 1, 1937, stating that you would continue mailing your official publication for the oncoming year. I wish to thank you for the numbers that have been received in the past, and also assure you of my personal pleasure and edification in perusing same. I think it is a great advantage to have the intimate contact with your state's activities which are outstanding.—J. Gurney Taylor, Milwaukee, Wisconsin."

"Your letter addressed to the officers and delegates of the American Medical Association regarding *CALIFORNIA AND WESTERN MEDICINE* reminds me that I should have heretofore acknowledged the receipt of this excellent *Journal* and expressed my interest in the viewpoints which appear in its departments. I am afraid I have not read every department in each issue. In view of your suggestion I will try to do so. I am sure I shall be rewarded.—Charles H. Goodrich, President, Medical Society of the State of New York."

"Thank you very much for *CALIFORNIA AND WESTERN MEDICINE*. It has been very helpful in getting a better understanding of medical problems presenting in California.—R. L. Sensenich, South Bend, Indiana."

"I do get a great deal of information from its pages and wish to congratulate the California Medical Association on having such an efficient secretary and editor.—Louis J. Hirschman, Detroit, Michigan."

"I read every word of the California *Journal*. I much admire the publication, it is not surpassed by any medical journal that comes to us in our exchange arrangement.—Charles J. Whalen, Editor, Illinois State *Journal*."

"As Chairman of the Editorial Board of *Minnesota Medicine*, I am profoundly interested in *CALIFORNIA AND WESTERN MEDICINE* perhaps a little more so than as a delegate of the American Medical Association. I shall continue to welcome its coming.

"The editorial columns are always of interest. The activities of your Association and the comments thereon are worthy of careful reading and thought. The make-up and general appearance of the *Journal* show a great deal of thoughtful care on the part of those responsible.—J. T. Christison, St. Paul, Minnesota."

"I have been much interested in looking over the articles from time to time which appear in CALIFORNIA AND WESTERN MEDICINE, especially the ones that have described your difficulties pertaining to California. I appreciate receiving the *Journal* very much.—H. B. Everett, Memphis, Tennessee."

"I am just in receipt of your very kind favor in which you say the CALIFORNIA AND WESTERN MEDICINE journal will continue to come for another year. May I say that I greatly enjoy reading your *State Journal*. I consider it the very best *State Journal* I have ever seen and I am sure doctors living without the bounds of your State, I mean those who have been privileged to read the *Journal*, have been disabused if they ever entertained an idea that your State Association has ever encouraged or fostered anything but the highest ideals of medical ethics and practice. I know that you have more problems with which to deal than most any other state, but I feel quite sure that the medical profession of California will be able to solve its problems.—John W. Burns, Cuero, Texas."

"I have found time to read your *Journal* regularly and appreciate it as much as any other publication that comes across my desk. I find that it is always full of thought producing suggestions which are valuable to American medicine and to the American people.—A. T. McCormack, Secretary, Kentucky State Medical Association."

"I have enjoyed reading the various issues and feel that they have given me a better understanding of the problems in California and throughout the country.—John H. Fitzgibbon, Portland, Oregon."

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

WHEN DOCTORS DISAGREE*

There are indications that the United States is moving slowly toward federalized medicine. But that does not mean that the United States is going to have it. American democracy is still a long way from subjecting its citizens to such compulsion and control.

Most recently the Medical Society of the State of New York passed a resolution which in effect favored "socialized medicine" and medical care for the "financially indigent" provided by the Government and at its expense. This resolution was passed on to the American Medical Association's meeting for action. But the larger and more conservative parent body dodged the issue, merely affirming its general willingness to cooperate with the Government at Washington, while retaining an attitude of austere and dignified passivity toward the whole matter. It did recommend the setting up of a national department of health under which all governmental health agencies could be centered.

The national medical organization also reaffirmed its stand against health insurance, because it does not think that kind of insurance adequate. This attitude may have been confirmed and influenced by the recent experience of British Columbia, where an experiment with health insurance is proving highly troublesome. When the Province was unable to put into operation a bill establishing health insurance because of opposition mainly led by doctors, the Premier called for a plebiscite. He demanded a clear mandate on a comprehensive health insurance plan progres-

sively applied. The returns from that balloting showed a majority favoring health insurance, but that majority fell far short of the mandate desired by the Government. It rather served to emphasize the strong minority that might make such sumptuary legislation unenforceable. The Government of British Columbia is in a dilemma again.

Last week, also, Senator Lewis of Illinois warmly invited the medical profession to join President Roosevelt in a move to effect federalized medicine. Scarcely was the sonorous and persuasive voice of the senior Senator from Illinois stilled when a spokesman at the White House hurriedly denied that the President had any specific program. Certainly the experience of British Columbia with its model health insurance law and the doctors' unwillingness to embark on a program of federalized medicine should give pause to anyone who has thoughts of experimenting along this line in America.

FORESTRY MEDICAL SERVICE

Attention of the members is drawn to the fact that the "Forestry Medical Service of the California Medical Association" is the only and official organization endorsed by this Association.

This "Service" was organized at the request of Federal and State Forestry Departments and the California Chamber of Commerce for the purpose of rendering emergency medical care in the event of major forest fires. It is so recognized by these organizations.

Regional Directors are: Karl L. Schaupp, Central Coast District; Junius B. Harris, Sacramento Valley District; Irving S. Wills, Southern California District; W. C. Shipley, North Coast District; Harry E. Kaplan, Central Valley District, and Mr. William Sparling, San Joaquin Valley District.

Membership is restricted to county medical society members.

This announcement is made so that members may not be confused by the representations that may be made by others.

COMPONENT COUNTY MEDICAL SOCIETIES

CONTRA COSTA COUNTY

At a special meeting held Wednesday evening May 12, 1937, in Richmond, the Contra Costa County Medical Society unanimously voted to petition the Insurance Association of Approved Hospitals to extend its activities to Contra Costa County. In adopting this resolution the Society also went on record as favoring a plan whereby the Contra Costa area would be represented, in an advisory capacity at least, in the administration of the Association.

The following Contra Costa County hospitals were declared "approved": Richmond Cottage Hospital, Martinez Community Hospital, Concord Hospital, and Antioch Hospital. Should the above petition be favorably acted upon by the Association, the Medical Society recommends that the above named hospitals be favorably considered for participation in the Association.

Also unanimously adopted was a resolution that the Contra Costa County Medical Society apply for membership in the Insurance Association of Approved Hospitals when and if the Association extends its activities into Contra Costa County.

This petition, together with the list of approved hospitals and the application for membership in the Association has been sent to the secretary of the Association for consideration by the Board of Directors at its meeting Friday evening, May 14.

Letters have been sent to the four hospitals mentioned informing them of these actions taken by the Society.

The following members of the Contra Costa County Medical Society were present at the meeting: Clara H. Spalding, President; Walter L. Taylor, Vice-President; Thomas J. Dozier, Secretary-Treasurer; U. S. Abbott, Kaho Daily, M. L. Fernandez, E. B. Fitzpatrick, Harry G. Ford, L. H. Fraser, L. A. Hedges, William A. Powell, J. B. Spalding, and Sol. N. Weil.

† The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. Charles A. Dukes of Oakland is the chairman, and Dr. F. C. Warnshuis is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. F. C. Warnshuis, Room 2004, Four Fifty Sutter Street, San Francisco.

* From the *Christian Science Monitor*, June 18, 1937.

Also present were: Dr. Daniel Crosby, President, Insurance Association of Approved Hospitals; Mr. George U. Wood, Second Vice-President, Insurance Association of Approved Hospitals and Superintendent of Peralta Hospital; Mr. Philo Nelson, General Manager of the Association, and Mr. Jack Rafter, Manager of Richmond Cottage Hospital.

THOMAS J. DOZIER, *Secretary*.

MARIN COUNTY

The Marin County Medical Society held its monthly meeting on June 24, 1937, at the Marin Golf and Country Club. It was a well attended meeting, and Dr. Philip Gilman of Stanford gave a very interesting talk on *Thyroid Diseases*.

CARL W. CLARK, *Secretary*.

SAN BERNARDINO COUNTY

The joint meeting of the Tri-County Dental Society and the San Bernardino County Medical Society was held at the California Hotel in San Bernardino on Tuesday, June 1, 1937. Dinner was served at 8:00 p. m. with about sixty members and guests present.

The following applications for membership were favorably voted on: Dr. V. G. Slater, San Bernardino; Dr. E. H. Lum, Claremont, and Dr. Jacob Janzen, Loma Linda.

Nominations for officers for 1937-1938 were called for. There being no further nominations it was moved and seconded that the officers nominated by the Board of Directors stand approved, as follows: President, Dr. Delbert Williams; First Vice-President, Dr. V. M. Pinkley; Second Vice-President, Dr. Floyd W. Gardner; Secretary-Treasurer, Dr. Arthur E. Varden; Delegates, Dr. A. D. Neubert, Dr. Walter Cherry, and Dr. X. Olsen; Alternates, Dr. A. L. Weber, Dr. T. I. Zirkle, and Dr. R. C. Nichols.

The paper of the evening was *Physical Diagnosis, Its Relation to Dentistry*, by William Nance Anderson, M. D.

Following the discussion, the President, Dr. D. C. Mock, again thanked the members of the Dental Society for their attendance, and expressed a wish on behalf of our Society that more joint meetings be held.

ARTHUR E. VARDEN, *Secretary*.

SAN DIEGO COUNTY

On June 15, Dr. Frank H. Krusen, Director of Physical Therapy, Mayo Clinic, spoke to the San Diego County Medical Society. His subject was *Present Status of Physical Therapy*.

Applications for membership were received from the following:

Francis M. Findlay, Harvard; Gerald F. Banks, University of California; William C. Satterlee, College Medical Evangelists; Berenice I. Stone, University of Wisconsin; Frank C. Konrad, Harvard; E. H. Calvert, Ohio; Richard T. Hamer, College Medical Evangelists; Anton S. Yuskis, Rush; Kerwin W. Kinard, Pennsylvania; G. F. Harris, University of Southern California, and James B. Couche, Toronto.

F. E. TOOMEY, *Chairman*.

SOLANO COUNTY

Solano County Medical Society was host to a Tri-County Medical Society meeting held at the Vallejo Golf Club on Saturday, July 10, 1937. Guests were the Napa County Medical Society and the Sonoma County Medical Society. A number of doctors played golf in the afternoon.

Doctor Perkins, President of the Solano County Medical Society, turned the meeting over to Dr. Ream Leachman, after a dinner served at the Golf Club at 7:00 p. m. Doctor Leachman introduced the speakers and acted as Master of Ceremonies for the evening.

Mr. Hartley Peart of San Francisco, general counsel for the California Medical Association, spoke of *Queer Quirks of the Law as applied to the practice of medicine*. He was followed by the associate counsel, Mr. Baraty.

Dr. Junius Harris of Sacramento then told of the recent session of the Legislature and referred to bills interesting

us as doctors, and particularly the one vetoed by the Governor which dealt with fees as "Expert Witness." He also referred to current comments on Socialized Medicine revealed at the recent meeting of the American Medical Association.

Dr. James Eaves of San Francisco spoke on the *Tri-Counties in Connection With Industrial Medicine*, suggested a "panel" of local doctors to take care of industrial cases and also consultations pertaining to the same.

Dr. James Dillon of San Francisco then spoke on *Present Trends in Urology*, and referred to the use of prontosil and sulfanilamide, also ammonium citrate and mandelic acid in treatment of infections of the urinary tract. His remarks were then discussed by Doctor Marshall, who is head of the Urological Department of the Mare Island Hospital. Doctor Marshall recounted his experience with sulfanilamide and said it was extremely useful in the treatment of gonorrhea, sometimes reducing treatment to a period of one to three weeks. He said he believed there may be bad effects from its use, and that it should be used only under the direct supervision of a doctor. He cited patients in whom the red cells were profoundly reduced and the whites correspondingly elevated. General discussion followed.

Dr. Henry Rogers, Councilor of our District for the California Medical Association, then made some interesting remarks concerning the California Medical Association.

There were thirty-three present, including doctors from Petaluma, Santa Rosa, Pasadena, Napa, Sonoma, Sacramento, Fairfield, Napa State Hospital, Benicia, Mare Island Hospital, San Francisco, and Vallejo.

JOHN W. GREEN, *Secretary*.

VENTURA COUNTY

The regular monthly meeting of the Ventura County Medical Society was held at the Saticoy Country Club on Tuesday, May 11, 1937.

Dr. C. G. Baumgartner gave an illustrated lecture on the *Common Surgical Emergencies of the Abdomen*. He briefly discussed appendicitis in children, peptic duodenal ulcers, and intestinal obstructions.

A brief report of the Del Monte meeting was given by the delegate.

Doctor Shore moved and Doctor Clark seconded that a letter offering our congratulations and cooperation be sent to the new Councilor of our District, Doctor Packard of Bakersfield. Motion carried.

Doctor Coffey discussed the testing of school children for tuberculosis. Various members seemed to feel that since everyone else connected with this movement received some remuneration that the medical profession, with the exception of the school physicians, should receive some compensation. The opinion was expressed that this movement would be broadened and the burden on the individual member's time would be increased unless we took some definite stand on this question. No final action was taken.

A. A. MORRISON, *Secretary*.

CHANGES IN MEMBERSHIP

New Members (26)

Alameda County.—Franklin C. Cassidy, James T. Harkness, Hewitt H. Robinson, Paul C. Samson.

Humboldt County.—John S. Chain, Samuel P. Burre.

Kern County.—Joseph D. Johnson, J. Headen Inman.

Kings County.—Harold A. Hinckley.

Los Angeles County.—Isabel DeY. Brown, George M. Campbell, O. H. Hanson, Gurn T. Stout.

Mendocino-Lake County.—Holden E. Brink, L. J. Callahan, Otto L. Gericke.

Monterey County.—T. D. Englehorn, John H. Gratiot.

Riverside County.—Frederic D. Ullrich, Leonard D. Wood.

Sacramento County.—William F. Harding, P. L. Koch, Milton Sarkisian.

San Francisco County.—Arthur Horace Rice.

Santa Barbara County.—Robert V. Carter, Yoshitaka Nakano.

Transferred (4)

Benjamin L. Bryant, from Santa Clara County to Los Angeles County.

C. E. Burk, from San Bernardino County to Washington Medical Association.

J. H. Mallery, from San Diego County to Oregon State Medical Association.

John C. Sharp, from Santa Clara County to Monterey County.

Resigned (3)

Bertha Dymont, from Santa Clara County.

Robert Hector, from Alameda County.

George P. Waller, from Los Angeles County.

In Memoriam

Ball, Charles Dexter. Died at Santa Ana, June 16, 1937, age 78. Graduate of the University of Bishop College Faculty of Medicine, Montreal, 1884. Licensed in California in 1887. Doctor Ball was a retired member of the Orange County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Brown, Harry Ver Brike. Died at Glendale, June 26, 1937, age 64. Graduate of Bennett College of Eclectic Medicine and Surgery, Chicago, 1902. Licensed in California in 1907. Doctor Brown was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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Coe, Harry Carson. Died at Oakland, June 11, 1937, age 46. Graduate of Stanford University School of Medicine, San Francisco, 1922, and licensed in California the same year. Doctor Coe was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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Farmer, Lydia Etta. Died at Sacramento, July 1, 1937, age 64. Graduate of College of Physicians and Surgeons, Keokuk, Iowa, 1893, and licensed in California the same year. Doctor Farmer was a retired member of the Sacramento Society for Medical Improvement, the California Medical Association, and the American Medical Association.

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Gray, Frank Pierce. Died at San Francisco, June 28, 1937, age 84. Graduate of Cooper Medical College, San Francisco, 1895, and licensed in California the same year. Doctor Gray was a retired member of the San Francisco County Medical Society, the California Medical Association, and the American Medical Association.

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Smith, Munford. Died at Sea, June 28, 1937, age 45. Graduate of the University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, 1919. Licensed in California in 1920. Doctor Smith was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

OBITUARIES**Newbern Nuckolls Brown****1883-1937**

WHEREAS, It has pleased the Infinite to remove from our professional ranks and from the midst of this community, by an untimely death, our esteemed professional co-laborer and friend, N. N. Brown, M. D., who has for the past, more than a quarter of a century, occupied a prominent position in the medical profession of Kern County, California, and an enviable position in the hearts of the people of this community; therefore, be it

Resolved, That in the death of N. N. Brown, M. D., we have sustained the loss of an able friend whose fellowship it was an honor and a pleasure to enjoy; that we bear willing testimony to his many amiable virtues and to his unquestioned professional ability and probity and to a life devoted to the benefit of his fellowmen; that we offer to his bereaved family and his host of mourning friends, over whom sorrow has hung her black mantle, our heartfelt condolence and pray that the Infinite One will bring speedy relief to their sorrowed and burdened hearts; and be it further

Resolved, That a copy of these resolutions, properly engrossed, be presented to the family of our deceased friend; that a copy thereof be given to our local press; that a copy be sent to our State Association.

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Munford Smith**1892-1937**

Munford Smith, age 45, died suddenly on June 28, 1937, on board the *M. S. Canada*, en route for England via the Panama Canal. From radio advices the cause of death was some form of cerebral vascular accident.

Doctor Smith, a graduate of the University of Maryland Medical School, had been in Los Angeles since 1919. A year later he became assistant resident physician at the Barlow Sanatorium, and had continuously been connected with the Sanatorium from that time until his death. For the past ten years he had held the position of medical director. In this capacity, he has been responsible for the care of some two thousand patients who have passed through the institution in the past ten years.

In the last few years he had been much interested in the effect of the inhalation of dust and noxious gases—a subject in which he was a recognized authority. He was a member of the Los Angeles County Medical Association, a Fellow of the American Medical Association, and a Fellow of the American College of Physicians. National recognition of his ability is expressed by his membership on the Board of Directors of the National Tuberculosis Association and he had recently completed a term as president of the American Sanatorium Association. Active and interested in the larger aspects of public health as applied in particular to his specialty, he had served on many important committees for the betterment of the charitable care of pulmonary tuberculosis.

Doctor Smith was an unusually able clinician with a wide experience in diseases of the chest. He possessed rare judgment in the selection of various methods of treatment for patients suffering from pulmonary tuberculosis, and it is due chiefly to his efforts that successful collapse therapy has been widely, but judiciously, employed at the Barlow Sanatorium. His kindness of spirit and keen interest in people and their personal as well as medical problems made his particularly successful in the conduct of cases of chronic illness. To Dr. Munford Smith's thoughtful and intelligent advice, there are hundreds of individuals in Southern California who now owe their lives and their well-being.

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Harry V. Brown**1873-1937**

Doctor Harry V. Brown, former vice-president of the Los Angeles County Medical Association and former president of the Glendale Branch, and for many years a Councilor and a member of the Association, passed away on Friday, June 25.

Doctor Brown was sixty-two years of age. He was born in Chariton, Iowa, and was graduated from Drake University, Des Moines, later taking post-graduate studies at Harvard and at Stanford Universities.

He came to California in 1907, first practicing in Los Angeles and moving to Glendale twenty years ago, where in addition to his professional activities, he at once identified himself with the civic life of the community.

Doctor Brown, for ten years, was a member of the board of trustees of the Glendale Union High School District, acting as president for one term, and also served as a member of the board of trustees of the Glendale Public Library.

His passing causes much sorrow among his host of friends in the Association.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

News Letter

Dear Auxiliary Members:

You are all interested, I know, in some of the more intimate phases of the recent convention held at Atlantic City. From nothing could you obtain a more graphic picture of the friendliness and good fellowship that exists among Auxiliary members than from the charming speech of welcome by Mrs. George A. Rogers of East Orange, New Jersey, and the sincere and gracious reply of Mrs. Hobart Rogers of Oakland, our President. I am happy to have been able to print for you excerpts of these addresses.

Yours sincerely,

MRS. FRED H. ZUMWALT.

ADDRESS OF WELCOME

Once again Auxiliary members have gathered together from all parts of the United States to compare experiences, report results and enjoy a holiday.

It is my privilege to greet you all in the name of New Jersey and her neighbors, Pennsylvania, and Delaware. Though so many here are strangers, in that we have never met before, yet the bond of our common interest is strong and we hold out the hand of fellowship to welcome you as our friends.

While Auxiliary business is of primary importance during this convention, still we trust that you will all find time and opportunity to enjoy the many pleasures which Atlantic City has to offer.

It is our hope, that when the time comes to say "Good-bye," you will leave us with regret but looking forward to the day when we shall meet again.

Once more I offer you a most hearty welcome.

MRS. GEORGE A. ROGERS,
East Orange, N. J.

RESPONSE TO THE ADDRESS OF WELCOME

It is my lot to live where, from my windows, I may view the Golden Gate and the blue Pacific beyond. Within a few days I have passed through the canyons of the Rockies, crossed the vast and somber western plains, the sheltered farm lands of the Middle West and on through the industrial communities of the East. I am happy and proud to have made this journey. I mention it now only that it symbolizes our geographic separation from one another and perhaps, therefore, justifies my presumption in speaking on behalf of the Woman's Auxiliary to the American Medical Association in responding to the welcome so graciously expressed by Mrs. Rogers. We realize that, as we sit down to consider our mutual problems, we must overcome all these forces which tend to divide us. We must develop our hopes and aspirations in an atmosphere of friendliness and good cheer. This atmosphere you have already created for us.

To Mrs. Rogers, and to the ladies of the New Jersey, Pennsylvania, and Delaware Auxiliaries who have given so much in time, in effort, and in sacrifice for our comfort and happiness in this convention, may we express our sincere appreciation and our thanks. Especially do we thank you that you are making us feel not as strangers from afar but as neighbors and friends; not as poor and distant relations but as members of your own household. We shall enjoy your hospitality in the fullest measure, and we shall look forward to the day when we may open our doors to you.

MRS. HOBART ROGERS,
Oakland, California.

† As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Fred Zumwalt, chairman of the Publicity and Publications Committee, 3880 Clay Street, San Francisco. Brief reports of county auxiliary meetings will be welcomed by Mrs. Zumwalt and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the Editor to allocate two pages in every issue to Woman's Auxiliary notes.

Component County Auxiliaries

Marin County

The election of officers was held at the meeting of the Women's Auxiliary to the Marin County Medical Society on Thursday evening, June 24, at the Marin Golf and Country Club. The following were elected for the coming year: President, Mrs. Thomas Gocher; Vice-President, Mrs. Roy R. Robertson; Secretary and Publicity Editor, Mrs. R. B. Hartman; Treasurer, Mrs. Homer Marston.

Reports of the State Convention, held at Del Monte in May, were given by members who had attended. Word of the honor accorded Marin County in the election of Mrs. H. O. Hund as treasurer of the State Auxiliary for the coming year was enthusiastically received.

MRS. ROY R. ROBERTSON, *Secretary*.

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Sacramento County

The Woman's Auxiliary to the Sacramento Medical Society enjoyed a picnic luncheon and social afternoon on the fifteenth of June at the beautiful and spacious home of Dr. and Mrs. J. B. Harris.

Mr. Earl Barnett gave a talk on *Domestic Architecture of Foreign Countries* and Madame Iki entertained with songs.

During the summer months the members of the Public Health Committee are giving three mornings a week at the Tuberculosis Clinic, and will also assist the Red Cross at the State Fair in September.

The Auxiliary, through Mrs. William Van Den Berg, President, is one of the organizations sponsoring the Sacramento music series.

MRS. H. R. JOHNSON, *Publicity Chairman*.

Fifteenth Annual Convention of Woman's Auxiliary to the American Medical Association

Atlantic City, June 6 to 11, 1937

Notes

Dear Auxiliary Members:

The first general meeting was devoted to the President's report and the reports of the chairmen of standing committees. Mrs. Fitzgerald gave a résumé of the growth and expansion of the National Auxiliary. She states that no new and outstanding project had been undertaken this year, and that for the sake of unity and continuity, in our organization she had continued the aims and policies of her predecessors. She emphasized the fact that we are a secondary organization banded together to work under the direction of the parent group. Should we proceed independently of that body, we cease to be an auxiliary and violate the principles on which we are founded.

The reports of the chairmen of the various departments were very gratifying and showed substantial increases in numbers, activities, and usefulness. Each spoke especially of the fine cooperation of the various State Auxiliaries in carrying out the National program. Since to me the convention meant an intensive course of training for the coming year's work, I shall mention some of the helpful suggestions I gleaned from the reports.

Organization.—Mrs. David S. Long reported a substantial increase in counties organized. We now have organizations in thirty-seven states and the District of Columbia. New Hampshire, one of the states most recently organized, now has auxiliaries in all counties. Texas has forty-six counties organized with a total membership of 1,806. New York State came to the front with an increase in membership of 399½ per cent.

Looking toward the goal "Every County in Your State Organized," Mrs. Long has stressed four outstanding points:

1. Include in your state committee each county chairman of membership and organization. In unorganized counties, ask the State Advisory Council to petition the County Medical Society to name a county organizer.

2. Urge county chairmen to perfect their county organization by:

- (a) Making special efforts to reinstate delinquent members.

- (b) Interviewing every eligible doctor's wife.
- (c) Conducting at least one meeting a year on aims and purposes of a medical auxiliary.
- (d) Inviting doctors' wives from neighboring counties to your meetings.

3. Having your county chairman entirely familiar with the mechanics of organizing an auxiliary.

4. Being sure the county you are organizing really wants an auxiliary, as it takes enthusiasm to build a successful and permanent organization.

Hygiea.—Mrs. James D. Lester reported the largest number of *Hygiea* subscriptions in the history of the auxiliary. As you know, one of our National Past Presidents, Mrs. John O. McReynolds of Dallas, Texas, offered three cash prizes of \$50 each to the county securing the most subscriptions to *Hygiea*.

Public Relations.—The activities of this committee under the chairmanship of Mrs. J. Bonar White have been far-reaching. With the coöperation of the state units it has been able to promote health education in various organizations, such as Parent Teacher Associations, Pre-School Associations, Federated Women's Clubs, Health and Recreation Committees of Young Women's Christian Associations, Girl Scout and Camp Fire Girls' Councils, Farm Women's Clubs and many others. It has encouraged Health Essay Contests, Public Health Days, Health Institutes, Health Poster Contests, and many other projects to promote a better understanding between the medical profession and the lay public. A most important objective of an auxiliary is to direct public thinking and action to channels mutually advantageous to the profession and the citizens generally.

Program.—Mrs. V. E. Holcombe reported that the program of State Auxiliaries has been varied according to individual needs. The key note of each, however, has been health education.

Following the reading of these reports our new National President, Mrs. Augustus S. Kech of Altoon, Pennsylvania, was presented. She is a dynamic person of great capacity and charm. She is a natural leader and she speaks exceedingly well.

Exhibits.—One of the most popular and interesting features of the convention was the exhibits under the very able direction of Mrs. Ily R. Beir. New York had on display a replica of the inside of a living room with a nurse teaching pre-natal and infant care to mothers. Another was the interior of a house in the tenement district depicted before and after free instructions as to cleanliness and orderliness were given by members of an auxiliary group. Utah presented a three-ring circus with germs illustrated in animal forms and the doctor as a scientist eradicating the germs. This was in direct contrast to the illustrations of various forms of quackery, i. e., patent reducers, fake cancer cures, nostrums, vegetarian quackery, etc.

Many states had maps showing the growth of their auxiliaries. Kentucky added to this feature of their map, the areas in which doctors, nurses, and auxiliary members did voluntary duty during the devastating floods of the past winter. Many states had charts showing their activities: Supplying books for hospitals, contributing layettes and shoes for indigent children, paying for braces, doing sewing in hospitals, giving Christmas parties in orphanages, filling and distributing baskets of food and clothing at Christmas time, and many other worthy projects. The scrap books of numerous states were of especial interest as a record of their auxiliary year by year. Many pictures, cartoons, newspaper clippings, etc., added spice and life to the books. Their members will recall many very pleasant associations as they turn the pages of these books through the passing years.

California was represented by six delegates. It was my pleasure to be asked to respond to the address of welcome given by Mrs. George Rogers of New Jersey. Mrs. Philip Schuyler Doane of Pasadena was elected chairman of the Revisions Committee. Mrs. Doane presented the National Auxiliary with a silver trophy to be presented yearly to the State Auxiliary showing the largest percentage increase in membership. This was received enthusiastically and will no doubt stimulate membership drives. It was won by New York this year. Do you think that California may win it next year?

As you no doubt know, the convention next year will be held in San Francisco. There is some understandable reluctance on the part of the governing bodies to bring these conventions to the Pacific Coast, away from the more populous Eastern centers. I trust, therefore, that all of our members who have friends and acquaintances among the profession in the East will endeavor to persuade them to attend. It is essential that our own members make every effort to be present. May I urge that all of you be ready and willing to give any assistance the convention committee may ask. We must remember also that the doctors and their families who attend the convention will be, many of them for the first time, visitors to California and the West. Let us extend to them every courtesy and endeavor to make their entire stay thoroughly enjoyable.

Finally, may I express to you my appreciation of the opportunity of attending this Fifteenth Annual Convention, in Atlantic City, as your President. I trust that some of the ideas gleaned and the contacts made may be helpful in our work through the coming years.

Very sincerely yours,

MRS. HOBART ROGERS.

Developments in the Antivenereal Disease Campaign in Germany.—By the terms of the law of June 1, 1933, the granting of small loans to couples who wed is contingent on the results of an official medical examination. No loan is granted to any applicant who is suffering from a venereal disease which carries with it the danger of contagion. Practically, this mandatory examination was the basis for a refusal of subsidies to 9,065 (2.7 per cent) of 333,776 applicants during the latter half of 1934 and the first half of 1935. The rejection of 547 applications was based on the existence of a contagious venereal disease: syphilis in 422 instances and gonorrhea in 125 instances. In addition, 209 rejections were made on the grounds of sterility and incapacity for child-bearing, conditions which also may be traced in great measure to some venereal infection.

The law of October 18, 1935, stipulates that a marriage cannot be contracted if one of the betrothed is affected with a contagious disease that might endanger the health of the marriage partner or of the offspring. An engaged couple must obtain from the bureau of health a certification to the effect that no such impediment to marriage is present. The German Antivenereal Disease Society under the presidency of Professor Spiethoff has formulated the following guiding principles with respect to potential contagion: Syphilis is generally considered contagious for four years subsequent to infection. Syphilis is considered as no longer transmissible if four years has elapsed since infection and if after an adequate therapy no symptoms have been manifested for two years. The foregoing periods may be shortened on the basis of scientifically established cure. In gonorrhea in the male patient the urine and prostatic secretion must be negative for gonococci (even for threads) during at least one examination weekly over a period of three months. It is mandatory that these follow-ups be based on recognized scientific provocative tests. If the data so warrant, a shorter period of observation will be deemed sufficient. In the case of a woman gonorrhea patient, it is stipulated that after completion of treatment three months should elapse during which no gonococci are demonstrable (in the urethra, cervix, gland of Bartholin or rectum) at follow-ups conducted at least once each week. As in the case of the man, proper provocative tests are compulsory. Examination before, during and immediately after menstruation is particularly conclusive. Here, too, the period of observation may be shortened on the basis of satisfactory scientific proof of cure. The record, only just made public, of violations of the antivenereal disease law during 1933 is as follows: In all, 346 defendants were convicted, almost exactly the same number as in 1932. Of these 346 persons, 196 were sentenced for indulging in coitus while afflicted with a venereal disease, two for contracting marriage while afflicted with a venereal disease and failure to inform the partner of the illness, 135 for unauthorized treatment of venereal disease and offers to perform such treatment, twelve for attempting to sell appliances alleged to cure or palliate venereal disease, and there was one conviction for violation of the clause which prohibits the suckling of infants by venereal disease sufferers.—Berlin Correspondence, *Journal of the American Medical Association*.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, San Francisco, June 7-11, 1938. Olin West, M. D., 535 North Dearborn Street, Chicago, Secretary.

California Medical Association, Hotel Huntington, Pasadena, May 9-12, 1938. F. C. Warnshuis, M. D., 450 Sutter Street, San Francisco, Secretary.

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Idaho State Medical Association, Boise, August 30 to September 3. Harold W. Stone, M. D., 105 North Eighth Street, Boise, Secretary.

Utah State Medical Association, Salt Lake City, September 2-4. F. M. McHugh, M. D., 17 Exchange Place, Salt Lake City, Secretary.

Medical Broadcasts*

Los Angeles County Medical Association

The radio broadcast program for the Los Angeles County Medical Association for the month of August is as follows: Thursday, August 5—KECA, 10:45 a. m., The Road to Health.

Saturday, August 7—KFI, 9:15 a. m., The Road to Health; KFAC, 10:15 a. m., Your Doctor and You.

Thursday, August 12—KECA, 10:45 a. m., The Road to Health.

Saturday, August 14—KFI, 9:15 a. m., The Road to Health; KFAC, 10:15 a. m., Your Doctor and You.

Thursday, August 19—KECA, 10:45 a. m., The Road to Health.

Saturday, August 21—KFI, 9:15 a. m., The Road to Health; KFAC, 10:15 a. m., Your Doctor and You.

Thursday, August 26—KECA, 10:45 a. m., The Road to Health.

Saturday, August 28—KFI, 9:15 a. m., The Road to Health; KFAC, 10:15 a. m., Your Doctor and You.

Division of Immigration and Housing: California Department of Industrial Relations.—During the month of May, ninety-nine labor camps were inspected; twenty-three camps were listed as good, forty fair and twenty-eight bad, and eight closed. Of the total number of camps inspected, fifty-three were old camps and thirty-eight new ones. In the camps inspected it was found that 3,616 occupants were American born, while 1,133 were foreign born, making a total of 4,749, of which 2,487 were men, 1,197 women and 1,065 children.

During the month eighty auto camps were inspected; thirty-eight were listed as good, twenty-two fair, thirteen bad, and six closed. Three hundred and sixty-six housing inspections were made.

The fact that this division has taken the initiative in preparing model ordinances dealing with housing and sanitation in their many ramifications has had a stimulating effect upon cities and counties toward enacting much needed legislation along those lines, and our advice and assistance is now constantly in demand.

The division has pioneered local trailer camp legislation and our model trailer ordinance is now in effect in ten Southern California cities and many other communities have used it as a basis for more comprehensive regulation. Its ordinance banning squatter camps and setting up standards for other types of camps is in effect in one county and two or three other counties have it under consideration for adoption.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Nationalizing Medicine Urged.—The following news item is of interest when read in connection with the editorial, "Government Medicine." (See pages 75, 117, 120, and 141 in this issue:

"On July 28 Senator Lewis (Democrat) of Illinois asked Congress to nationalize the medical profession.

"He introduced a resolution to make doctors Federal employees."

Woman Scientist Given High Honor.—In recognition of her twenty years' work in psychology and preventive psychiatry for children, the honorary degree of Doctor of Science has been conferred on Dr. Olga Bridgman by Mills College in Oakland. Doctor Bridgman is professor of pediatrics and psychology at the University of California at Berkeley, and in the University Medical School.

Doctor Bridgman has been a pioneer in the work of establishing a union between psychiatry—the science of healing mental ills—and pediatrics, or children's medicine. Psychiatric treatment of young children is now recognized as a valuable preventive measure, and has become an important part of the science of child healing.

Doctor Bridgman established a children's psychiatric unit as part of the pediatric department of the University Medical School more than twenty years ago. A similar close union of psychiatrist and child specialist has recently been established at Johns Hopkins University, Harvard and Pennsylvania.

In conferring the degree on Doctor Bridgman, Dr. Aurelia Henry Reinhardt, President of Mills College, characterized Doctor Bridgman as a "student of the inter-relationships of the mind and body, healer of the ills of childhood, that maturity may be free of deep-rooted sicknesses."

Certified Milk.—A new era in certified milk which, it was predicted, should advance certified milk nutritionally as far as it has been advanced sanitarily, was begun at the joint annual conference of the American Association of Medical Milk Commissions and the Certified Milk Producers' Association of America recently held in Atlantic City.

The first symposium on nutrition ever conducted by the milk industry was held during the conference and pooled the thoughts of some of the leading scientists of the country including Dr. E. V. McCollum of Johns Hopkins University, Baltimore. Every factor in improving the already high nutritional qualities of certified milk and in using that milk properly in the nutrition of mankind was thoroughly discussed.

Frederick B. Carter, Jr., operator of Arden Certified Farm, El Monte, California, was elected president of the Certified Milk Producers Association of America.

Breast feeding of new-born infants is rapidly disappearing among the modern young mothers in large communities, Dr. Harry S. Bikoff, Assistant Pediatrician of the Jewish Hospital, Brooklyn, told the conference. Artificial feeding is necessary and for this purpose the very best form of cow's milk is undeniably certified milk, due to the stringent regulations necessary for its production and distribution, he added.

The whole problem of improving milk quality is traceable directly back to the problem of improving soil fertility, it was asserted by Dr. J. G. Lipman of New Jersey Agricultural Experiment Station, New Brunswick, New Jersey.

Physicians and pediatricians should be educated to the fact that there is a decided difference between certified milk and other grades of milk and a mighty small difference in actual value between the grades of milk other than certified, Dr. Harold L. Barnes, retiring American Association of Medical Milk Commission president, said.

University of California Medical School Course on Handling of Venereal Disease.—A special course on the handling of venereal disease will be offered to physicians at the University of California Medical Center, Third and Parnassus Avenues, San Francisco, beginning Monday evening, August 23. The meetings will be at 8 p. m., in Room 437, Fourth floor, University of California Clinics Building.

The course will consist of ten sessions to be held Monday and Friday nights for five weeks through September 24. The first two sessions will be devoted to bacteriology and pathology, the next three to the pharmacology of the drugs concerned, the next four to the practical clinical management and the final session to the public health aspects of the problem. Illustrated case material will be drawn from the clinics held regularly on Monday and Friday nights.

There will be no charge for this course of instruction. It is open to any qualified physician.

Stanford Post-Graduate Medical Courses.—Post-graduate medical courses for practicing physicians will be given by Stanford University School of Medicine in co-operation with the San Francisco Department of Public Health and the San Francisco Hospital on September 6-10, 1937, inclusive.

There will be a registration fee of \$25. An additional fee of \$10 will be made to cover the cost of material used in Course Six, Surgical Anatomy and Operative Technic. Each physician may take a morning and an afternoon course and all physicians should attend the evening general meetings. Registration closes September 1, 1937. Applications for registration in these courses should be mailed to the Dean, Stanford University School of Medicine, 2398 Sacramento Street, San Francisco, not later than September 1.

MORNING COURSES

Course 1—X-ray Diagnosis and Therapy (For doctors experienced in and practicing Radiology, but not limited to those who are specializing exclusively in Radiology). Course by Drs. L. H. Garland, Edward Leef, Eric Liljencrantz, and R. R. Newell.

Course 2—Emergency Surgery and Fractures—(At San Francisco Hospital). Course by Drs. J. W. Cline, Nelson Howard, Donald King, Carleton Mathewson, J. M. Meherin, E. J. Morrissey, W. L. Rogers, and E. B. Towne.

Course 3—Diseases of the Genito-Urinary Tract. Course by Drs. J. R. Dillon, and L. R. Reynolds.

Course 4—Cardiology and Electrocardiography (Limited to fifteen physicians). Course by Drs. A. L. Bloomfield, G. D. Barnett, William Dock, J. K. Lewis, William H. Newman, and J. M. Read.

AFTERNOON COURSES

Course 5—Diagnosis and Treatment of Malignant Tumors. Course by Drs. J. R. Dillon, L. G. Dobson, L. H. Garland, E. F. Holman, Donald King, Eric Liljencrantz, R. R. Newell, F. L. Reichert, Robert Scarborough, D. A. Wood.

Course 6—Surgical Anatomy and Operative Technic (Limited to twenty-four physicians). Course by Drs. Donald King, G. W. Nagel, and R. E. Scarborough.

Course 7—Diagnosis, Treatment, and Control of Syphilis. Course by Drs. C. W. Barnett, G. S. Johnson, and G. V. Kulchar.

Course 8—Ward Rounds in Medicine (Limited to fifteen physicians. Course by Drs. Thomas Addis, A. L. Bloomfield, Garnet Cheney, L. B. Dickey, H. K. Faber, P. H. Pierson, and David Rytand.

Course 9—Clinics in the Medical Specialties. Monday, Tuesday, Wednesday, Thursday, and Friday, 1:30 to 5. Course by Drs. H. E. Alderson, A. L. Bloomfield, J. F. Card, William Dock, S. H. Hurwitz, A. E. Ingels, G. S. Johnson, G. V. Kulchar, M. T. R. Maynard, and W. F. Schaller.

GENERAL MEETINGS

These will be held Monday and Wednesday evenings in Lane Hall, 8 to 10 p. m.

Meeting 1—Evaluation of Recently Introduced Drugs: Dr. M. L. Tainter, Monday evening, 8 to 10.

Meeting 2—Problems in Industrial Health: Dr. W. P. Shepard, Wednesday evening, 8 to 10.

Life Insurance Companies and the Medical Profession.—Dr. Donald B. Cragin, medical director, Aetna Life, retiring chairman of the American Life Convention, in a recent address, gave the results of a questionnaire from 197 companies in regard to the amounts paid the medical profession in the year 1936. For medical fees, plus compensation, plus accident and health and leaving out state insurance, automobile liability, self-carriers, contract practice, a large portion of group and industrial payments, the figure reached the stupendous sum of \$70,386,097.42.

From reliable sources an estimate can be made of well over \$100,000,000 paid by all companies for medical services in the United States. It was estimated that about \$800,000,000 was paid for medical services by individuals in this same year, and it is also interesting to note that \$360,000,000 was paid for patent medicine.

Doctor Cragin felt from these figures that the insurance companies were justified in trying for a closer bond between the companies and the medical practitioner and felt that if the figures were understood by the profession at large that, with the information which is available to the profession, statistics on longevity, heredity, and prognosis of disease, an entering wedge for closer cooperation and understanding would be afforded.

American Public Health Association.—The annual meeting of the American Public Health Association will be held October 5-8, in New York City. There will be special sessions on Mental Hygiene, the Hygiene of Housing, and on Public Health Advancing. Among the subjects chosen for joint sessions are Nutritional Problems, with the Child Hygiene and Food and Nutrition Sections; Water-Borne Diseases, with the Public Health Engineering and Epidemiology Sections; the Crippled Child, with the Child Hygiene and Public Health Nursing Sections and Syphilis in Industry, with the Industrial Hygiene and Public Health Nursing Sections. There will be an intensive three-day Institute on Public Health Education before the annual meeting begins, sponsored by the Health Education Section and under the direction of Professor Ira V. Hiscock of Yale University. The Scientific Trips Committee with all of New York's multitudinous official and non-official health agencies to choose from, is preparing a program of inspection trips that alone would merit attendance at the convention. The American Association of School Physicians, the National Organization for Public Health Nursing, the Federation of Sewage Works Operators, and several other allied national groups will join with the American Public Health Association in a series of scientific sessions. All inquiries should be addressed to the American Public Health Association, 50 West Fiftieth Street, New York City.

California Industrial Accident Commission: Safety Department.—The accident prevention work of the Industrial Accident Commission began in 1914 in a small way. During that year there were 691 industrial deaths and the population of the State was estimated at 2,832,398. For every 4,100 people in the State there was an industrial death. The estimated population for 1936 is 6,800,000. Had the 1914 industrial death rate continued there would have been 1,660 industrial deaths in 1936, whereas there were actually but 563.

This indicates that the industrial death rate from 1914 to 1936, has been reduced about 66 per cent. During the years 1926 to 1935, inclusive, there were 437 accidents reported to the Commission for every death reported.

It is estimated that the lives of more than 11,000 employees have been saved by the accident prevention work done by the employees, employers and the Commission. If that estimate is correct, there were almost five million personal injuries prevented during this same period.

Regardless of what may be said concerning the accuracy of these estimates there can be no denial of the fact that thousands of lives have been saved and millions of personal injuries prevented.

Today the problem is not "How many lives have been saved?" but "How can the present accident situation be improved?" There is only one answer: more complete cooperation between the employees and employers with the Commission.

The American College of Physicians.—The Twenty-second Annual Session of the American College of Physicians will be held in New York City, with headquarters at the Waldorf-Astoria Hotel, April 4-8, 1938.

Dr. James H. Means, of Boston, is President of the College, and will have charge of the program of general scientific sessions. Dr. James Alexander Miller, of New York City, has been appointed General Chairman of the Session, and will be in charge of the program of clinics and demonstrations in the hospitals and medical schools and of the program of Round Table Discussions to be conducted at headquarters. For information, address E. R. Loveland, Executive Secretary, 4200 Pine Street, Philadelphia, Pennsylvania.

University of California Slash: Merriam's Budget Cut Cripples Program.—Press dispatch follows: San Francisco, July 20.—President Robert Gordon Sproul of University of California submitted to the Board of Regents today what was described as a schedule of wholesale abandonment of programs and activities necessary to expedient operation of the school.

Curtailment is necessary, Doctor Sproul said, because Governor Merriam slashed an emergency budget request of \$455,000.

The board is considering discontinuance of the agriculture crop survey, elimination of salary adjustments for sixty to seventy-four professors, general reductions at the School of Medicine, and postponement of plans to keep the Medical School's Class A standing.—*Los Angeles Examiner.*

Campaign Against Trichinosis Will Be Carried to Producers.—To acquaint swine producers more fully with the need to prevent infestation of their hogs with small parasites, known as trichinae, the United States Department of Agriculture is sponsoring a program of information on the subject. This activity among producers is a counterpart of a similar campaign conducted among consumers for many years to induce them to cook pork thoroughly as a safeguard against trichinosis.

In a recent circular letter, Dr. John R. Mohler, Chief of the Bureau of Animal Industry, directs each inspector in charge of Federal veterinary activities in the principal hog raising states to designate a member of his force to contact farmers and other swine producers individually and in meetings for the purpose of more effective control of trichina infestation in hogs.

"These contacts," he states, "should be made as often as opportunities for doing so present themselves and should be continued over a period of several years." Doctor Mohler points out that the persistence of trichinosis in man is likely to react unfavorably sooner or later on the swine industry and injure it financially. The trichinosis educational campaign is expected to prevent such an occurrence.

The Bureau of Animal Industry's recommendations, as set forth in the official letter to inspectors, are in part as follows:

Inasmuch as investigations conducted in the bureau have shown that the incidence of trichinae in garbage-fed hogs is much higher than in hogs not fed on garbage, it is essential to stress that the feeding of raw garbage tends to spread trichinosis among swine. Other sources of trichinosis in swine are: (1) The feeding of offal from slaughterhouses; (2) the feeding of the contents of scrap barrels; (3) the failure to bury, burn, or otherwise dispose of hogs or other animals which die on lots and pastures and which may be eaten by hogs.

A strict adherence to the swine sanitation program, as developed by the Bureau of Animal Industry, will aid in preventing the spread of trichinae among hogs and will reduce the extent of infestation with these parasites. The sanitation system precludes the feeding of garbage, offal, kitchen scraps, and other food containing scraps of raw pork, and involves the use of clean pastures and sanitary housing. This system decreases the cost of swine production, favors the growth and development of pigs, and finishes pigs for market at six to seven months of age. The system, if carried out as recommended, will reduce if not eliminate altogether trichinosis in swine, since it removes most of the known sources of trichinae.

"Overweight Mortality."—Pearce Shepherd, assistant actuary, Prudential, at the American Life Convention, presented a paper on "Overweight Mortality." Dr. H. A. Baker, medical director, Kansas City Life, termed this a most significant contribution. The overweight is definitely a better risk than forty years ago, he said, yet combined overweight and high blood pressure is an increasing risk. Glycosuria is more frequently found among overweights. E. M. McConney, vice-president and actuary, Bankers Life of Iowa, also discussed the paper. He feels overweights are a worse risk today due to cardio-vascular-renal diseases to which they are subject being in a rising curve. Medical science, he said, has done little to improve the mortality of overweights. He concluded the time may be at hand when a joint mortality study on combinations of impairments should be made.

Maryland Eradicates Bovine Tuberculosis—Other States Make Progress.—Maryland is the forty-fourth state to eradicate bovine tuberculosis. It became a modified accredited area July 1—that is, infection among cattle is reduced to less than one-half of 1 per cent as shown by the tuberculin test—the United States Department of Agriculture reports.

Three other states also were conspicuously successful in tuberculin-testing work during June. California reported the following counties for modified accreditation: El Dorado, Lake, Sacramento, and Yuba. New York officials reported the necessary progress, to accredit four counties, Chenango, Delaware, Lewis, and Otsego.

In South Dakota, officials in charge of tuberculosis eradication work reported five counties: Brown, Hyde, Jerauld, Moody, and Spink, as accredited. Similar work is being conducted in Puerto Rico where seven municipalities were placed in the modified accredited area July 1.

Rabies.—Rabies in dogs is subject to periodic waves of increase in different regions. Only recently an extensive outbreak occurred in Chicago. Many persons were bitten and deaths from human rabies occurred. In connection with this matter the following statement in the review for 1936 by the president of the Rockefeller Foundation is highly significant: "In 1936 the Foundation began laboratory and field work in relation to rabies, which has become an increasing menace, particularly in some of the Southern states. Little has been done on this disease since Pasteur's day; and it is hoped that a quicker and more positive test for rabies in animals may be developed, and perhaps a less cumbersome method of vaccination." The very best that can be said for the one injection of antirabies vaccine is that it is still no further than in the experimental stage. Whether many dogs have developed rabies after the injection of live viruses is extremely difficult to determine, but that possibility cannot be denied. Negri bodies are sufficiently characteristic to be regarded safely as diagnostic, but the examination of suspected cases, like all examinations of such nature in general, are, of course, reliable only in competent hands.

American Pharmaceutical Association.—Since the issuance of the first list of fifty-four corrections in *National Formulary VI* in June, 1936, the committee on *National Formulary* has carefully studied other suggested corrections in the text and have compiled a second list of thirty-six corrections to be made in the first and second printings of the *National Formulary VI*, bearing official coupons with serial numbers from 100,001 to 135,260. The corrections have been approved by the Council of the American Pharmaceutical Association, and corresponding corrections will be made in subsequent printings of *National Formulary VI*.

A list of these corrections, with an index, printed on one side of the sheet and in type corresponding to that replaced, is available, without cost, and is so arranged that the sheets can be inserted in the front of the *National Formulary VI* or that each correction can be cut out and pasted over the wording it is to replace.

Requests for corrections in *National Formulary VI* (second list), may be sent to Mack Printing Company, Easton, Pennsylvania, or the American Pharmaceutical Association, 2215 Constitution Avenue, Washington, D. C., and must give address and be accompanied by sufficient postage to insure delivery.

American Board of Obstetrics and Gynecology.—The next written examination and review of case histories of Group B applicants by the American Board of Obstetrics and Gynecology will be held in various cities in the United States and Canada on Saturday, November 6, 1937.

The next general examination for all candidates (Groups A and B), will be held in San Francisco, California, on June 13 and 14, 1938, immediately prior to the American Medical Association meeting.

Application blanks and booklets of information may be obtained from Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania. Applications for these examinations must be filed in the secretary's office not later than sixty days prior to the scheduled dates of examination.

Doctor Worth \$108,000 To Begin Career, Rating.—United Press ditpatch follows:

New York, July 14.—After eight years of research, a Columbia University professor came to the conclusion today that a doctor is worth \$108,000 as an investment when he starts his profession, a lawyer \$105,000, and a farm laborer \$10,400.

Professor Harold F. Clark, in charge of educational economics at Teachers College, undertook his study in an attempt to develop means of guiding students more accurately into paying professions.

He concluded that a banker could invest safely \$108,000 in a budding doctor on a promise of receiving all of the physician's future earnings. The average life span of a doctor is forty-two years, it was estimated. On a similar basis, Clark figured the following "safe" investments in other professions:

Dentistry, \$95,400; engineering, \$95,300; architecture, \$82,500; college teaching, \$69,300; social work, \$51,000; journalism, \$41,500; ministry, \$41,000; library work, \$35,000; public school teaching, \$29,700; skilled trades, \$28,600; nursing, \$28,300; unskilled labor, \$15,200; farming, \$12,500.

"Wonder Woman" in Pasadena.—The following news item has been sent in by a member, with suggestion that it be printed:

See this WONDER WOMAN OF 83. She's a living example of pep, youth, and radiant health. ———, author, world traveler, scientist, who will show you the way to the fountain of youth, life, energy, and vitality. *Six Free Radiant Health Lectures.* Twice daily, July 19, 20, 21. Monday, July 19, 1:30 p.m.: "Old at Forty or Young at Eighty—Which?" Monday, July 19, 8 p.m.: "How to Conquer Fear, Worry and Timidity." Tuesday, July 20, 1:30 p.m.: "The Four Causes of Disease." Tuesday, July 20, 8 p.m.: "How to Become a Human Dynamo or Prosperity Magnet." Wednesday, July 21, 1:30 p.m.: "Rhythmic Solar Plexus Breathing—the Elixir of Life." Wednesday, July 21, 8 p.m.: "The Secret of Youth, Pep and Charm."

Would You Like to Know—How to feel peppy, twenty-four hours a day; How to increase your business efficiency a thousand fold; How to develop the elasticity of youth; How to take years—from your personal appearance; How to capture the enthusiasm and zest of youth; How to develop a magnetic personality; How to eat scientifically—and rebuild a complete new body; How to get a quick pick-up—without the aid of stimulants; How to sleep like a child; How to awaken in the morning with pep, interest, enthusiasm; How to reduce your weight—without fasting; How to get rid of corns, bunions, and fallen arches—and step out with the grace and the lightness of youth; How to throw away your glasses—and read with ease; How to outwit age completely—and live joyously, radiantly and gloriously—regardless of youth birthdays.

Something New—This is the most amazing course of lectures ever given in this city. Mrs. ———, herself is a striking example of rejuvenation. Twenty years ago she was old and decrepit. Today, she is radiant, dynamic, beautiful. She has inspired thousands to health, happiness, and success—Why not you? You owe it to yourself not to miss a single lecture. All lectures are free but come early to get good seats. Doors open at 12:30 and at 7 p. m. Shakespeare Club House, Pasadena.

LETTERS

Concerning Association Secretary's Address to the California State Nurses Association.

THE CALIFORNIA STATE NURSES ASSOCIATION, INC.

Dear Doctor Warnshuis:

As Secretary for the California State Nurses Association's Committee on Public Information and at Headquarters, I wish to convey the official appreciation of the organization for your fine address at the Publicity Luncheon on Friday.

We were happy to have you present as the official representative of a professional organization whose interests are so closely allied to ours.

I need not tell you that we were deeply interested in your message, as the attention of the nurses during your presentation must have been ample evidence of this fact.

It is characteristic of the preparation of registered nurses to give their loyal support toward upholding the standards of the medical profession. Registered nurses recognize that it is dangerous for public welfare to have inadequately prepared individuals attempt to prescribe for human ills.

We trust that the nursing organization may have the full support of the members of the medical profession in upholding standards of nursing care as we, too, suffer from pseudo-practitioners.

Thanking you both officially and personally, I am

Cordially yours,

STELLA M. FREIDINGER,
Acting Director at Headquarters.

Concerning Venereal Disease Reports.

STATE OF CALIFORNIA
DEPARTMENT OF PUBLIC HEALTH

To the Physicians of California:—The venereal disease control program is now under way. The first objective is as follows:

EVERY CASE OF VENEREAL DISEASE TO BE REPORTED

The California State Board of Health on January 2, 1937, altered the reporting of venereal diseases to conform in general with the recommendations of the United States Public Health Service.

A new card is enclosed herewith. You are asked to destroy all the old type cards you may have. Additional cards may be obtained by placing a check, or the number desired, in the square placed on the card for this purpose.

Syphilis and gonorrhea are reportable by law, failure to report constituting a misdemeanor.

In reporting, fill out the card, place it in the envelope which is provided and which requires no postage, and address the envelope to your local health officer or to the State Department of Public Health, State Building, San Francisco. These reports are confidential records and are to be handled as such by health departments. You will note that they need not reveal the identity of your patient.

The information requested on the card is essential in order that we may know the incidence and distribution of these diseases. This information is fundamental in any control program.

Venereal disease control is dependent upon coöperative efforts. The full support of the practicing physician is of first importance. This support begins with the reporting of all cases. May we urge your coöperation in this respect?

In addressing the recent Washington Conference on Venereal Disease Control, on the subject of coöperation of the private physician, Dr. Udo J. Wile, Professor of Dermatology and Syphilology, University of Michigan Medical School, said in part:

The whole-hearted coöperation of the private physician in the program of national control of a communicable disease is not only an imperative necessity but carries with it an obligation of public and private responsibility. In assuming the care of a case of communicable disease, the physician assumes a dual responsibility. He is obligated to the patient in the first place, to carry through with him until such time as he ceases to be a public health problem. His second responsibility, a more public one, is, by strict adherence to existing regulations, to carry out such measures as are prescribed by health authorities so that

during the patient's infective period he is of little or no risk to those with whom he comes in contact. . . .

From the standpoint of vital statistics, and for the immediate purposes of the study of venereal disease incidence, it is of paramount importance to recognize that earnest and sincere coöperation on the part of the practicing physician is required to fulfill the obligation of reporting, which is of first importance in the control of any communicable disease. There is no doubt that considerable reluctance, based upon the traditional relationship between physician and patient, still exists which may retard the immediate success of venereal disease reporting. Nevertheless, in the light of public interest and of an awakened public consciousness, this tradition is being modified where public interest so requires. Reporting by name already exists in some states, and there can now be no legitimate objection to reporting, at least by initial or number and address, under all circumstances with the condition that such information remains of a confidential nature so far as public health officials are concerned, and can in no way be used to endanger the reputation or character of those concerned. . . .

The State Department of Public Health, through the recently formed Bureau of Venereal Diseases, is anxious to be of every possible help to physicians in the care of venereal disease cases. A special bulletin on the treatment of syphilis is enclosed and it is hoped that it will prove helpful to you.

An announcement of the second objective in the venereal disease program will reach you in the near future.

MALCOLM H. MERRILL, M.D., *Chief
Bureau of Venereal Diseases
State Department of Public Health
coöperating with
U. S. Public Health Service.*

Approved:

WALTER M. DICKIE, M.D.,
Field Agent, U.S.P.H.S.

Concerning Donation to the Barlow Medical Library.

June 17, 1937.

To the Association Secretary:—I have just returned from the Convention of the Medical Library Association, and find a notation of a gift of \$1,242.75 from the California Medical Association.

These annual contributions enable us to purchase for the Library many items of medical literature which otherwise we could not have. The more extensive the library, the better service we can render to the doctors of the County and State.

We express our appreciation and thanks for this generous gift.

Yours very truly,
MARY E. IRISH,
Librarian.

Concerning the Pan American Medical Cruise.

PAN AMERICAN MEDICAL ASSOCIATION

June 19, 1937.

To the Editor:—The Executive Committee of the Board of Trustees takes great pleasure in announcing that the *Queen of Bermuda* has been chartered for the Seventh Cruise-Congress. As you know, we had this boat for the last cruise and it proved to be most ideal for our purposes. Following is the itinerary:

Leave New York.....	January 15, 1938
Arrive Havana (4½ days and 5 nights in Havana).....	January 18, 1938
Leave Havana.....	January 23, 1938
Arrive Port au Prince.....	January 24, 1938
Leave Port au Prince.....	January 24, 1938
Arrive Trujillo City (Santo Domingo).....	January 26, 1938
Leave Trujillo City (Santo Domingo).....	January 26, 1938
Arrive San Juan (Puerto Rico).....	January 27, 1938
Leave San Juan (Puerto Rico).....	January 27, 1938
Arrive New York.....	January 31, 1938

The main part of the Congress will be held in Havana. There will be three days of scientific sessions with operative clinics. These will be divided into sections for the various specialties. This year we have four new sections: Tuberculosis, gastroenterology, dentistry, and industrial medicine. Meetings will be arranged with our medical colleagues at the other ports of call.

The Hotel Savoy-Plaza in New York, and the National Hotel in Havana will be our official hotels.

Travelways, Inc., have chartered the *Queen of Bermuda* on behalf of our Association and will act as our official travel agents. As this Congress promises to be the most successful ever held by the Association, it would be highly advisable to book reservations as early as possible with Travelways, Inc., who will make every effort to satisfy the requirements of the members of the Congress. Applications for reservations should be addressed to the Pan American Medical Association at 745 Fifth Avenue, New York City.

The program committee would be pleased to receive applications for the presentation of scientific contributions.

Cordially yours,

JOSEPH J. ELLER, M. D.

Office of Director General,
745 Fifth Avenue, New York, N. Y.

Concerning Donation to the Lane Library.

To the Association Secretary:—At the last meeting of the Board the President of the University advised us of the receipt of check for \$1,242.73 from the California Medical Association as a contribution to the Lane Medical Library.

The Trustees deeply appreciate this generous action on the part of the Association, and I was requested to extend, through you, their profound thanks to the members of the Association.

Yours very truly,

IRA S. LILLYCK, *Secretary.*

Concerning: "If and when we have State Medicine."

To the Editor:—What will be the status of the specialist if and when we have State Medicine? How will the various specialties be classified? How will the men in the different branches be selected, on the basis of years of practice, years of post-graduate work, or by the number and kind of influential political friends, or on the basis of competitive examination, similar to civil service?

Will post-graduate work be encouraged? If so, will the State pay for it, pay for the time off, similar to army regulation? Who will designate the places to study? Will that be left to the discretion of the individual physician, or will it be controlled by a board? If by a board, will it be composed of doctors or laity?

What will be the psychological reaction of the mass of the profession toward the compulsory attendance of patients? What will be the stimulus for exhaustive study of puzzling cases?

Will every section of the human anatomy be divided for special study, and be under the jurisdiction of a specialist in that part? If so, what will be the result obtained by the narrow specialist in relation to other ailments of the same individual? Will it be necessary to have a dozen specialists in consultation if a patient should complain of symptoms in different parts of the body?

What will be the inducement to physicians to write scientific articles?

What will be the relation of physician to patient? What if an illiterate patient decides that the physician attending the case is not competent—will he go to the lay committee to complain, or will he go to some politician friend to have the doctor disqualified, or reduced in rank?

If State Medicine becomes a practice, can the State stop there? What effect will it have upon the new graduates? Are they to become specialists as soon as they graduate, or must they go out in the field as general practitioners? If as specialists, who will pay for their time and tuition? The hospitals in which they study will have to conform to some degree with the plan, and will they, as a consequence, be supported by the State? What then will become of the private donations to these institutions? If private bequests are withdrawn, will that increase the amount necessary to support the institution to be given by the State, and will that in turn increase the State's budget and in turn increase the taxes?

If the physician is a State agent, will the medical students attending the State schools be subject to pay the present rate of medical tuition? If cheaper, what will become of the private schools?

What will become of the various medical societies? What will be their value? Certainly not for medical protection,

for if State Medicine comes, that in itself will show that the medical societies are not capable of protecting their interests. Certainly not to protect the lay people against themselves, because that will be too late. Will it be necessary to belong to a medical society to be in good standing? Do State officers, clerks, judges, and various other State employes belong to fraternities in order to be in good standing?

If there is a change in the political situation, will the general practitioner of today be the specialist of tomorrow? If there are one hundred graduates, and a vacancy for only fifty doctors, what will become of the other fifty? Or will the State regulate the number it will need to be permitted to graduate or enroll? If a physician who is in ill health, or for other reasons needs to or desires to make a change from one state to another, will it be necessary to make a political application, medical application, or wait for a quota, or wait for a vacancy?

If there exists an old-age law, will the doctor be removed after a certain age, and be placed on a pension? Will a surgeon be replaced at a younger age than a general practitioner?

Who will be responsible for malpractice suits, the doctor or the State?

If each physician asked himself each one of the foregoing questions, and made an attempt to answer as he thinks the situation might be, we would have a more concise idea as to the precise effect upon us and the laity if and when we have "State Medicine."

6253 Hollywood Boulevard, Hollywood.

HAROLD I. HARRIS.

Concerning the use of Healing Art Degrees by Persons not licensed in California.

(Copy)

STATE OF CALIFORNIA
LEGAL DEPARTMENT

San Francisco, July 9, 1937.

C. B. Pinkham, M. D.,
Secretary-Treasurer,
Board of Medical Examiners,
450 McAllister Street,
San Francisco, California.

Dear Sir:

I have your communication of the fourteenth instant in which are asked the following questions:

"May the holder of a certificate as a physician and surgeon, licensed by the Osteopathic Board in this State, who is a graduate of the Rush Medical School, Chicago, and who holds from that school the degree of M. D., use the term M. D. on his professional cards, or otherwise, in connection with the term D. O., without infringing the State Medical Practice Act?

"In the event your answer is that such a physician and surgeon may not use the term M. D., then I should like to know if the term D. O. and M. D. could be used by such certificate holder, not for the purpose of practicing professionally, but as a member of the faculty of a non-accredited school for the purpose of teaching?"

In reply, please be advised the use of the suffix "M. D." on a professional card would, in my opinion, violate that portion of Section 17 of the Medical Practice Act of this State which prohibits a person not licensed under said act from using in any sign or advertisement the letters "M. D."

The Legislature, in my opinion, has the right to prevent persons possessing such degree from using the same for the purpose of securing professional business, unless they be licensed.

The fact of being licensed by the Osteopathic Board as a physician and surgeon is not important. Such a person cannot use professionally the suffix "M. D." without being licensed by the Medical Board.

The same situation would prevent a physician and surgeon licensed by the Board of Medical Examiners from using the expression "D. O." or any term indicating he was licensed as an osteopathic physician and surgeon.

As to your second question, it is the view of this office that the Legislature has no right to limit the use of a personal degree if its action will not in some way serve to protect the public. A person possessing and using a *bona*

fide degree, not in connection with the practice of medicine, could in no way impose on members of the public.

Teaching cannot be said to ordinarily constitute the practice of profession or a holding oneself out as so doing. For example, the teaching of chemistry, physics, or anatomy would not be practicing medicine.

However, should a person advertise himself as an "M.D." without licensure by the Board of Medical Examiners, and either examine or diagnose members of the public, a violation of the law would follow. (*People vs. Jordan*, 172 Cal. 391.)

Very truly yours,

U. S. WEBB, *Attorney General*.

By (signed) LIONEL BROWNE,
Deputy.

LB:F
JJE 1439

Concerning Animal Rabies in Los Angeles County.

STATE OF CALIFORNIA
DEPARTMENT OF PUBLIC HEALTH

June 24, 1937.

To the Editor:—You are familiar with the rabies situation in Los Angeles, and what we have done in supporting Doctor Parrish in his efforts to have a ninety-day quarantine ordinance adopted by the City Council. The opposition to rabies control measures, in my opinion, comes from the manner in which they are carried out. The old method of procedure was to have police officers and deputy sheriffs shoot dogs on sight, and arouse the antagonism of dog owners and the general public.

We recommend that a limited quarantine be placed on all dogs; that owners of dogs be requested to confine them to their premises or exercise them on a leash; that the humane society be requested to collect all stray dogs; that a proper pound or place of retention be established under the supervision of a man who understands dogs (preferably, of course, a veterinarian); that dogs be retained in the pound for sufficient time so that owners may claim them. At the end of a certain period of time, stray dogs should be disposed of in a humane manner. Owners should be advised to vaccinate their dogs.

This may not be 100 per cent effective, but the two measures taken together, namely, the picking up of stray dogs and the vaccination of privately owned dogs, rapidly clears up the rabies situation. However, it is not an activity which can be undertaken sporadically, but should be a continuous activity in both the city and county health departments. I feel that the health departments would be justified in establishing a Rabies Control Division, and devote their time to the same.

One of the greatest difficulties we have had to contend with is that the dog tax in most places is a revenue tax. It has always seemed to me that dog owners who pay the tax should receive something in return; either free vaccination for their dogs, or their dogs should not be menaced by a stray dog population.

It has been suggested that, instead of depending on the Rabies Act, the Board adopt rules and regulations for the control of rabies, with special reference to the handling of actual cases and contacts. This would give the health officer a continuous authority to deal with the situation, rather than having to adopt local ordinances or to request the enforcement of the State Rabies Act.

Very truly yours,

W. M. DICKIE,
Director of Public Health.

CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH RABIES IN ANIMALS

Months	Los Angeles County Total		Los Angeles City		California	
	1936	1937	1936	1937	1936	1937
January	101	87	76	50	122	106
February	74	135	45	62	86	156
March	74	180	34	84	94	235
April	68	182	35	97	80	213
May	55	186	24	82	71	227
June*	71	119	30	61	95	137
July	51	.....	9	.....	83	.....
August	49	.....	16	.....	65	.....
September	61	.....	15	.....	81	.....
October	71	.....	30	.....	85	.....
November	62	.....	17	.....	83	.....
December	87	.....	33	.....	107	.....
Totals	824	889	364	436	1,052	1,074

* Month of June, 1937: first three weeks only

Concerning California's Migratory Workers Problem.*

STATE OF CALIFORNIA BOARD OF PUBLIC HEALTH SACRAMENTO

BOARD OF PUBLIC HEALTH	William R. P. Clark, M. D., San Francisco
Howard Morrow, M. D., President San Francisco	Gustave Wilson, M. D., Sacramento
Edward M. Pallette, M. D., Vice-President Los Angeles	Roy A. Terry, M. D., Long Beach
Walter M. Dickie, M. D., Executive Officer	George H. Kress, M. D., Los Angeles

To the Board Members:

A letter recently received from the United States Surgeon General makes reference to cooperation of local health departments and the State Department of Public Health with the Resettlement Administration. I am informed that at the present time there are between 150,000 and 200,000 migratory workers in the State of California. They have entered the State at the rate of about 50,000 a year. Many of these people are employed or seeking employment in the harvesting of the various crops in California. They have come from the south as well as from the drought areas and middle western states. They are poorly nourished, living for the most part on the vegetable products which they are harvesting. The Resettlement Administration is making a demonstration in the establishment of camps, the location of which is enumerated in the enclosed copy of letter from the Surgeon General. There are in these camps at the present time some 10,000 workers. One of these camps, at Marysville, has been in operation for about three years, and the population fluctuates from about thirty families in winter, to about two hundred in summer. These people are furnished shelter by the Government, but no subsistence, though many of them may be upon the relief rolls.

The chief of our Bureau of Tuberculosis, E. T. Thompson, first brought to our attention the prevalence of tuberculosis among these workers, and in order that a survey might be made to determine the extent of the incidence of tuberculosis, we requested from the Surgeon General funds to make a complete survey, taking the chest pictures of all suspects, which would involve the employment of personnel, a trailer and necessary equipment. This request has not as yet been granted by the Public Health Service, as it is contained in the budget for the second quarter of the fiscal year.

The Bureau of Child Hygiene of the California State Board of Public Health has been holding clinics among this group of people, making complete examinations of all the children. Of course, after these surveys have been made, the question naturally arises as to what we are going to do. As far as the tuberculous patients are concerned, the Bureau chief's idea seems to be the only one which would meet the emergency, namely, that the Government provide funds for a subsidy so that these people might be cared for in our private tuberculosis hospitals. I understand that Arizona is willing to cooperate in making such a request from the Federal Government.

Finally, there is the question of the effect these people camping on the outskirts of many of our communities is going to have upon the health of the people of California. Undoubtedly a large percentage of these people are going to qualify for county relief in case of illness, as soon as they have been in the State the required period of time, and they will then become our problem.

In talking with Mr. Mills, who heads the Resettlement Administration here in California, he states they would like to have us carry out the suggestion of the Public Health Service that we render assistance. We are, at the present time, subsidizing Imperial County with sufficient personnel so that they can take care of the camps of that county. The same would apply to Riverside County. Los Angeles County, according to Mr. Mills, has a negligible number of migratory workers. This leaves Northern California

and the San Joaquin Valley. By the employment of an epidemiologist or a medical man who had some experience in health work, and two nurses, one located in the San Joaquin Valley, which would include three hospitals, each one of them fifty miles from the other two, and one in Northern California, would probably take care of the infectious diseases.

Provision has been made in these camps for clinic facilities, and the idea would be that the doctor could conduct a clinic at least twice a month in the various camps, and that these cases would be allocated to the health officer or the local unofficial agencies for care.

Though there are only about 10,000 in this group under the Resettlement Administration, there are marginal camps surrounding these government camps which have probably a population which is in greater distress, and they would have to be included.

In addition, of course, our Department is always available in case of an emergency. Our greatest fear among this population is an outbreak of typhoid fever. We have had a decided increase in the incidence of typhoid during the past year among itinerants, and an epidemic of twenty cases in San Bernardino County.

This subject will be brought up for discussion at the next meeting of the Board.

Very truly yours,

W. M. DICKIE,
Executive Officer.

Concerning Retiring President Pallette's Address on "Human Betterment."

To the Editor:—My compliments to Dr. E. M. Pallette of Los Angeles, Retiring President of the California Medical Association, for his wonderful article on "Human Betterment" (May issue, CALIFORNIA AND WESTERN MEDICINE, page 296). This article should be read by everyone all over the country. Doctor Pallette has stated some very patent truths.

We modern humans are suffering from a load of human misfortunes that will fast become a serious problem. What with our earnest endeavor to relieve pain, save, and prolong life, we have reduced infant mortality to a minimum and extended the longevity of man to almost a maximum, having thoroughly upset nature's balance of elimination of the unfit. As a result of the reduction of infant mortality we are getting an increase of the feeble-minded, the criminal, the mentally and physically unfit, all of which will become a social and financial problem to the next generation.

Rosenberg Building, Santa Rosa, California.

Very truly yours,

W. C. SHIPLEY, M. D.

Concerning Untoward Effects of Sulphanilamide.

Los Angeles, July 13, 1937.

Editor, California and Western Medicine,
450 Sutter Street,
San Francisco, California.

Dear Doctor Kress:

Since the more extensive use of Sulphanilamide recently, I believe it of interest to report seeing a case of extensive dermatitis involving almost the entire body, more specially neck, hands, and arms.

This particular patient did not carry out his physician's instructions. He failed to report for observation as soon as he should have and he failed to reduce the dosage as his doctor had told him.

This case illustrates the fundamental principle in all medication in that it may be an idiosyncrasy to the drug, or that the patient's elimination of this drug is subnormal and an accumulation resulted, or the dosage was too great for the individual.

1930 Wilshire Boulevard.

Very truly yours,

CHARLES R. CASKEY, M. D.

* See also in this issue: Editorial comment on page 74; and press clippings on pages 142 and 143.

MEDICAL JURISPRUDENCE[†]

By HARTLEY F. PEART, ESQ.
San Francisco

A Discussion of the Chapter on Medicine of the New Business and Professions Code of the State of California

The Legislature, at the session just concluded, enacted Senate Bill No. 133, introduced by Senator McGovern of San Francisco. This bill has received the approval of the Governor. It contains the chapter on medicine of the Business and Professions Code of the State of California. Upon becoming effective (ninety days after adjournment of the Legislature)* the chapter on medicine of the Business and Professions Code will replace the present Medical Practice Act.

The Business and Professions Code was drafted under the supervision of the California Code Commission, which was created some years ago for the purpose of bringing about the codification of all existing statutes. In drafting the chapter on medicine, the expressed purpose of the Code Commission, to which it rigidly adhered, was to rephrase the language of the present Medical Practice Act in order to simplify and consolidate wherever possible without changing in any way the substantive law contained in the Act. Consequently, the chapter on medicine of the Business and Professions Code, as enacted by the Legislature, does not involve any material change in the existing law relating to the practice of medicine, but it does contain an almost complete revision of the structure and language of the Medical Practice Act.

We will not at this time endeavor to discuss the entire chapter on medicine, but will confine ourselves to a review of several of the general provisions which are of particular legal significance. The chapter on medicine consists of Sections 2000 to 2496 of the Business and Professions Code. At the outset, Section 2000 states: "Whenever a reference is made to the State Medical Practice Act by the provisions of any statute, it is to be construed as referring to the provisions of this chapter," thereby insuring the continuance in effect of those statutes, and there are a number of them, which refer to the Medical Practice Act. Section 2000 also has the effect of rendering the Business and Professions Code applicable to the osteopathic initiative.

The Code continues with definitions of various terms and then contains the following sections, which are of utmost importance to the medical profession:

2006. The term "person" means a natural person when a right, privilege or power is conferred by this chapter upon a person.

2007. The term "professional" relates to the art and science of medicine and surgery and to such other arts and sciences as may be included within the field of medicine and surgery.

2008. Corporations and other artificial legal entities have no professional rights, privileges or powers.

For a number of years controversies have existed with respect to the practice of medicine by various types of corporations. In at least two instances cases have been taken to the District Court of Appeal in order to determine what legal limitations existed upon the practice of medicine and surgery by a corporation (*Pacific Employers Insurance Company vs. Carpenter*, 10 Cal. App. (2nd) 592, and *Benjamin Franklin Life Assurance Company vs. Mitchell*, 85 Cal. App. Dec. 1058).

Should such a situation arise after the chapter on medicine of the Business and Professions Code has become

effective, it will only be necessary to refer to the statutes in order to secure an answer to both of the foregoing questions. With respect to the question of the lack of power of a corporation to practice medicine, Section 2008 specifically controls. The provision of Section 2008 that: "Corporations and other artificial legal entities have no professional rights, privileges or powers," can only mean that a corporation may not lawfully engage in any way in the practice of medicine and surgery. This is clear beyond question when one refers to Section 2007, which defines the word "professional" as relating to medicine and surgery.

With respect to the second question, *i. e.*, employment by a corporation of licensed physicians and surgeons to furnish professional services to persons selected by the corporation, it is likewise apparent that Sections 2006, 2007, and 2008 declare such conduct unlawful. Under Section 2006, any right, privilege or power conferred upon a person by the chapter on medicine only includes natural persons. Of course, one of the privileges conferred by the chapter is the privilege to practice medicine and surgery granted to those persons who hold physician's and surgeon's certificates. Section 2006 clearly means that all of the rights, privileges, and powers which each physician and surgeon possesses, by virtue of holding an issued and unrevoked physician's and surgeon's certificate, may only be exercised by the holder, a natural person, on his own behalf. Should a physician attempt to exercise any of the rights conferred upon him by his physician's and surgeon's certificate on behalf of a corporation, or should he attempt to delegate any of those rights to a corporation, such attempt could not legally be effective because every right, every privilege and every power granted to such physician by his certificate is limited to a natural person. Corporations, of course, are not natural persons. Sections 2007 and 2008 completely remove any doubt that might exist by expressly stating that the word "professional" realtes to medicine and surgery and that corporations have no professional rights, privileges or powers.

In the administration of the present Medical Practice Act the State Board of Medical Examiners has at times been handicapped by the lack of an express statutory provision prohibiting corporate encroachment into the field of medicine and surgery. The sections of the chapter on medicine of the Business and Professions Code, which we have been discussing, wholly remedy this defect. In the future it may be said with full assurance that in California a corporation may not legally practice medicine or surgery in any manner, directly or indirectly.

In connection with Section 2007, which defines the term "professional," it should be noted that many of the sections in the chapter on medicine relating to educational requirements require "professional instruction." These requirements are found in sections dealing with drugless practitioners as well as in sections dealing with physicians and surgeons. Also, by virtue of references in the osteopathic initiative, a number of the sections requiring professional instruction apply to osteopaths. Since "professional" is defined in Section 2007 as relating to the art and science of medicine and surgery, it is clear that wherever professional instruction is required, it must be instruction in those subjects which are included in the field of medicine and surgery.

It is felt that, in the Business and Professions Code, the California Code Commission has accomplished much in the field of clarification and orderly presentation of subject matter. Mr. Fred B. Wood, Secretary to the Code Commission, and Mr. Arthur McHenry, Statute Reviser for the Code Commission, devoted a great deal of time and effort to the preparation of the chapter on medicine. Their work has been carefully and skillfully done, and, in the years to come, will, without doubt, be fully appreciated, particularly by physicians who will be governed by the Business and Professions Code in the conduct of their profession, and by those of us who find it necessary constantly to study statutory provisions relating to the practice of medicine.

[†] Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, containing copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

* Editor's Note.—Law becomes operative on August 27, 1937.

SPECIAL ARTICLES

SOCIAL SECURITY ACT

Concerning Employees of Physicians

Operators of private laboratories, private sanitariums, and physicians employing one or more were advised today by Commissioner of Internal Revenue Guy T. Helvering to make immediate tax returns as required under the provisions of Titles VIII and IX of the Social Security Act to avoid further payment of drastic penalties which are now accruing.

Commissioner Helvering pointed out that every person employed in such work came under the provisions of Title VIII, which imposes an income tax on the wages of every taxable individual and an excise tax on the payroll of every employer of one or more. This tax is payable monthly at the office of the Collector of Internal Revenue. The present rate for employer and employee alike is 1 per cent of the taxable wages paid and received.

Under Title IX of the Act, employers of eight or more persons must pay an excise tax on their annual payroll. This tax went into effect on January 1, 1936, and tax payments were due from the employers, and the employers alone, at the office of the Collector of Internal Revenue on the first of this year. This tax is payable annually, although the employer may elect to pay it in regular quarterly installments.

The employer is held responsible for the collection of his employee's tax under Title VIII, the Commissioner explained, and is required to collect it when the wages are paid the employee, whether it be weekly or semi-monthly. Once the employer makes the 1 per cent deduction from the employee's pay, he becomes the custodian of Federal funds and must account for them to the Bureau of Internal Revenue.

This is done, Mr. Helvering said, when the employer makes out Treasury Form SS-1, which, accompanied by the employee-employer tax, is filed during the month directly following the month in which the taxes were collected. All tax payments must be made at the office of the Collector of Internal Revenue in the district in which the employer's place of business is located.

Penalties for delinquencies are levied against the employer, not the employee, the Commissioner pointed out, and range from 5 per cent to 25 per cent of the tax due, depending on the period of delinquency. Criminal action may be taken against those who wilfully refuse to pay their taxes.

The employers of one or more are also required to file Treasury Forms SS-2 and SS-2a. Both are informational forms and must be filed at collectors' offices not later than next July 31, covering the first six months of the year. After that they are to be filed at regular quarterly intervals. Form SS-2 will show all the taxable wages paid to all employees and SS-2a the taxable wages paid each employee.

Participation in a State unemployment compensation fund, approved by the Social Security Board, does not exempt employers from the excise tax under Title IX, Commissioner Helvering said. Nor does the fact that there is no State unemployment compensation fund relieve the employer of his Federal tax payments. In those states where an unemployment compensation fund has been approved, deductions up to 90 per cent of the Federal tax are allowed the employer who has already paid his state tax. These deductions are not allowed unless the state tax has been paid.

This tax is due in full from all employers in states having no approved fund. The rate for 1936 was 1 per cent of the total annual payroll containing eight or more employees, and for 1937 it is 2 per cent. The rate increases to 3 per cent in 1938 when it reaches its maximum. The annual returns are made on Treasury Form 940.

An employer who employs eight or more persons on each of twenty calendar days during a calendar year, each day being in a different calendar week, is liable to the tax. The same persons do not have to be employed during that period, nor do the hours of employment have to be the same.

Actual money, when paid as wages, is not the sole basis on which the tax is levied. Goods, clothing, lodging, if a part of compensation for services, are wages and a fair and reasonable value must be arrived at and become subject to the tax.

Commissions on sales, bonuses, and premiums on insurance are wages and taxable.

Officers of corporations whether or not receiving compensation are considered employees for the purpose of taxation.

Wages paid during sick leave or vacation, or at dismissal are taxable.

Traveling expenses required by salesmen are not wages if the salesmen account for, by receipts or otherwise, their reasonable expenditures. That part for which no accounting is made is construed as a wage and is taxable.

Exercise great care in filling out Treasury Forms SS-1 and 940. Directions are easy to follow and correct returns means no unnecessary delay.

BUREAU OF EPIDEMIOLOGY: CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH

Report for the Month of June, 1937.

The following report represents the activities of the Bureau of Epidemiology of the California State Department of Public Health during the month of June, 1937:

EPIDEMIOLOGICAL INVESTIGATIONS

1. *Food Poisoning*.—Fourteen cases in Fresno County were investigated at the request of the Health Officer. All had attended a school picnic celebrating the close of school. All had symptoms of acute food poisoning and bacillary dysentery. Food eaten was brought from the home of each of the children. Potato salad seemed to be the food involved. This salad was from six different places, making it difficult to definitely determine the source as no food was available for laboratory examination.

2. *Food Poisoning*.—Ten cases with three deaths in one family group were investigated at the request of the Fresno County Health Officer. All clinically had bacillary dysentery. Blood was obtained from two and agglutination reactions indicated that they were bacillary dysentery. As the family was living under insanitary conditions there was considerable evidence that the various members of the family contracted the disease either direct by contact or through the agency of flies.

3. *Food Poisoning*.—In running down the source of food poisoning in a boy scouts camp in Santa Barbara County a meat packing company in Los Angeles was investigated. The plant was found to be handling food products in a very sanitary manner.

4. *Jaundice, Epidemic*.—The investigation as to the cause of the outbreak of epidemic jaundice in an Eldorado County school in May was continued. The Bureau of Sanitary Inspection has been carrying on extensive trapping for rodents in the vicinity. Only a few new cases have developed since the last of May.

5. *Poliomyelitis*.—At the request of the Tulare County Health Department two cases were investigated. One was an adult migratory laborer, age twenty-two. His onset was May 28, and he had considerable paralysis. There were several slight illnesses in children in the family directly after his onset which may have been abortive attacks or due to other causes. The other case, a boy, age eight, had no contact with the previous case. The child had left Imperial County June 5 and arrived in Tulare County June 6, with onset June 9.

6. *Poliomyelitis*.—At the request of the Health Officer of Santa Barbara, a suspected case was investigated. The child, age three, was under treatment for lues and the question of differential diagnosis was brought up. There was considerable evidence that the case was a mild case of poliomyelitis.

7. *Rabies (Animal)*.—A meeting was held of representatives of the various Los Angeles County health departments with the County Supervisors for the purpose of adopting methods of controlling rabies in the area.

Also the rabies problem was discussed with the City of Los Angeles officials, as well as the County of San Diego.

8. *Suspected Rocky Mountain Spotted Fever*.—At the request of the Health Officer of Fresno, a suspected case

was investigated. The patient, a school teacher, had been on a fishing trip into Nevada, Idaho, Utah, and Arizona. When he returned he found a tick on his person. Four days later he ran a fever, headache, pains in shoulders, back, and abdomen. When seen two days after onset there was no sign of rash. Case proved not to be spotted fever.

9. *Smallpox*.—A case in San Bernardino County was investigated. There was a question as to diagnosis. The case proved to be typical mild smallpox and there were evidences of missed cases in the neighborhood.

10. *Smallpox*.—At the request of the Health Officer of Pasadena, several cases were investigated. Contacts of the first case came down with the disease, having been vaccinated too late after exposure.

11. *Smallpox*.—At the request of the Health Officer of Pasadena, a case under question as to diagnosis was investigated. The distribution was quite unusual but the lesions were typical of smallpox. In running down the source of infection several unrecognized cases were found.

12. *Typhoid Fever*.—Two cases in Tulare County were investigated. There was no connection between the two cases. Both were in rural territory and both were living under insanitary conditions conducive to the spread of the disease. Laboratory work was done on all contacts but no carrier was discovered.

13. *Typhoid Fever*.—Two cases in Sutter County were investigated. One was a baby six months old. Check of contacts revealed no possible carrier. The other case was in a woman whose onset was just a few days before termination of a normal pregnancy. No possible source of infection was discovered.

14. *Typhoid Fever*.—A case in Yuba County was investigated. The patient had been living in a tent on the Yuba River bank and had been drinking raw river water, although the water was subject to considerable contamination. This was undoubtedly the source of her infection.

15. *Typhoid Fever Carriers*.—Two known carriers in Marin County were visited in order to check up on their activities and sanitary conditions. One had moved to San Francisco.

16. *Typhus Fever*.—A mild case in Los Angeles was investigated. The case, a man employed in a packing house in the industrial portion of the city, gave a history of flea bites and onset six days later. Rats were on the premises of the place of employment.

17. *Undulant Fever*.—At the request of the Health Officer of Fresno, a case was investigated. The patient had been under treatment for several years for tuberculosis. Recently an agglutination reaction was obtained for undulant fever. Undoubtedly her onset dates back at least one year while she was living in the southern part of the State.

MISCELLANEOUS

At the request of the Fresno County Health Department, a survey was made of their methods of morbidity records and suggestions were made as to improvement in the system so that records would be more readily available for statistical purposes and at the same time not add unnecessary duties to the present staff.

MALARIA SURVEY

An extensive survey of the old malaria areas of the State was made in conjunction with representatives of the United States Public Health Service, the Bureau of Sanitary Engineering, and the Division of Entomology and Parasitology of the University of California. Areas around Sacramento, Fair Oaks, Roseville, Lincoln, Penryn, Marysville, Oroville, Yuba City, Los Molinos, Redding, Stockton, Lodi, Modesto, Bakersfield, Arvin, Fresno, Visalia, Porterville, Lindsay, Friant Dam, and Yosemite Valley were surveyed as possible mosquito breeding sites. Evidences of anopheles mosquitoes were hunted and methods of malaria control, especially spraying, were investigated.

PSITTACOSIS CONTROL

During the month of June, 1,532 shell parakeets and 249 other psittacine birds were shipped out of this State. In addition to the fifteen investigations involved in the inspections for checking the above shipments, eighty-six aviaries were inspected.

IMMUNIZATIONS

Typhoid immunization was continued among the migratory workers. A total of 2,182 injections were administered

in Kings, Tulare, and Kern counties. In Tulare County 462 persons completed the three doses and eighty-six in Kern County. The summary of the immunizations will be presented next month as all of the reports have not been received.

COMMUNICABLE DISEASE REPORTS

Table 1 represents the incidence of reportable diseases during the month of June, 1935, 1936, and 1937. There were four weeks during the months in 1935 and 1936 and five weeks in 1937:

TABLE 1.—Incidence of Reportable Diseases in California (For Months of June, in Years 1935, 1936 and 1937)

Disease	June 1937	June 1936	June 1935
Actinomycosis	1	..	2
Anthrax	..	..	..
Beriberi	1	1	..
Botulism	..	..	..
Chancroid	3	..	..
Chickenpox	2,989	1,390	2,688
Cholera	..	..	..
Coccidioides granuloma	6	5	2
Dengue	1	..	..
Diphtheria	157	127	135
Dysentery (amebic)	18	8	15
Dysentery (bacillary)	58	15	17
Encephalitis (epidemic)	4	..	2
Erysipelas	85	78	72
Food poisoning	97	89	193
German measles	1.4	707	2,410
Glanders	..	..	..
Gonococcus infection	1,392	813	880
Hookworm	..	1	6
Influenza	2,375	2,251	117
Jaundice (epidemic)	5	..	..
Leprosy	..	1	2
Malaria	14	10	4
Measles	1,239	5,611	4,542
Meningitis (epidemic)	17	19	22
Mumps	2,123	2,492	942
Ophthalmia neonatorum	1	1	3
Paratyphoid fever	6	6	4
Pellagra	10	14	18
Plague	..	..	..
Pneumonia (lobar)	212	261	214
Pollomyelitis	34	17	91
Psittacosis	..	..	..
Rabies (human)	1	..	..
Rabies (animal)	242	95	94
Relapsing fever	..	..	1
Rocky Mountain spotted fever	2	1	6
Scarlet fever	764	1,049	694
Septic sore throat	4	9	43
Smallpox	75	13	50
Syphilis	1,356	863	984
Tetanus	5	5	8
Trachoma	19	10	5
Trichinosis	1	3	2
Tuberculosis	705	616	.. 670
Tularemia	2	3	3
Typhoid fever	37	69	41
Typhus fever	..	2	..
Undulant fever	18	18	1*
Whooping cough	2,506	1,532	644
Yaws	..	..	..
Yellow fever	..	..	..
Totals	16,699	18,205	15,644

An increase for this season of the year is noted in chickenpox, diphtheria and whooping cough, even though there has been some decrease since early spring. Rabies is decidedly epidemic in some sections of the State, notably in Los Angeles County. The increase in the reports of gonorrhea and syphilis is due to the activities of the Bureau of Venereal Diseases, particularly to the letter sent to each physician and osteopath in the State supplying the new card and urging their cooperation in reporting cases under their care.

Respectfully submitted,

HARLIN L. WYNN, M. D.,
Chief, Bureau of Epidemiology.

CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH *

Report to Governor's Council

1. BUREAU OF ADMINISTRATION

Activities of the Director

The regular monthly meeting of the State Board of Public Health was attended May 2 and the annual meeting of the California State Medical Association was attended the following day. Most of the month was spent in the northern part of the State. At conferences held with the Director the following subjects were discussed. Legislation pertaining to the control of venereal diseases; prosecution of food violation cases in local courts; survey of rodents in mountainous districts; the proposed organization of a bureau of industrial hygiene; the training of sanitary inspectors; organization of whole-time county health units; the enforcement of the Cannery Act; the issuance of permits to operate oyster beds; the education of nurses; the control of rabies; dental hygiene; diagnostic clinics for crippled children; the proper labeling of canned dog foods; sewage disposal, and water supply.

2. BUREAU OF EPIDEMIOLOGY

Food Poisoning

With the beginning of warm weather, the occurrence of outbreaks of food poisoning began. Groups of cases involving nine persons in Santa Clara County, thirty-five in San Bernardino County and seventeen in Madera County were reported. It would seem that all of these outbreaks were due to the use of cold meats improperly refrigerated. The causative organisms were demonstrated in two of the outbreaks; in the other outbreak, no food like that consumed was available for laboratory study.

Epidemic Jaundice

An outbreak of this disease involving twenty-five or thirty pupils in a rural school of Eldorado County was investigated. . . .

Animal Rabies

Investigations in rabies and its control were made during the month. Rabies is exceptionally prevalent in Los Angeles City and County and in other portions of Southern California. During the week ending May 21, twenty-five rabid animals were reported in Los Angeles City and a marked increase in the number of rabid animals was noted in Los Angeles County. At the present time, more than one hundred individuals in the county are taking the Pasteur treatment. Local quarantines have been imposed in an effort to curb the spread of the disease.

Smallpox

Investigations into the prevalence of smallpox were made in Modoc, Lassen, and Riverside counties. Vaccination clinics were held in an effort to immunize as many school children and contacts as possible.

Because of the prevalence of smallpox in Siskiyou County, assistance was given in vaccinating school children. In ten different school districts, 710 children were vaccinated. A survey was made to determine the extent of vaccination in San Diego City and County. During the fiscal year, approximately 12,000 vaccinations were done in the city schools (public, parochial, and State College), and four thousand were done in the schools of the rural districts. It is expected another one thousand vaccinations will be performed during the month.

Typhoid Fever

Typhoid fever cases were investigated in Monterey, San Diego, Tulare, Fresno, and Santa Cruz counties. One case in a child was probably contracted outside of the State while the patient was visiting a relative in Kansas, who was determined by the Kansas State Health Department to be a typhoid carrier. Other cases involved swimming in a contaminated slough.

General Health Conditions

Chickenpox, mumps, smallpox, and whooping cough are more prevalent than usual. The number of cases of food poisoning reported show increases at the beginning of warm weather.

* By W. M. Dickie, M. D., Director of Public Health.

3. SANITARY INSPECTIONS

Rodent Survey

The rodent survey conducted by this bureau was carried on in sections of Stanislaus, Merced, Madera, Fresno, Placer, Eldorado, San Luis Obispo, and Santa Cruz counties. Among the rodents collected were common ground squirrels, golden mantled squirrels, tamarack squirrels, belding squirrels, chipmunks, white-footed field mice, flying squirrels, woodrats, shrews, house mice, ground hogs, rats, and rabbits. A total of 2,268 specimens was collected. Several thousand fleas were collected from the animals examined and sent to the laboratory.

Rodent Control Activities

The rodent control staff of the bureau inspected 18,226 acres of land and re-inspected 69,975 acres. Carbon bisulphide, grain poisoned with thallium and strychnin were used in control operations. Special investigations were made of the rodent situation in sections of the East Bay waterfront. Assistance was given in placing poisoned baits for the destruction of rats.

Stream Pollution

Investigations into stream pollution were made along Arcade Creek and American River in Sacramento County; Dry Creek in Placer County; Blue Jay, Dogwood, Hook, and Waterman creeks, and Santa Ana River in San Bernardino County; Pine, Los Angeles, Gorman, Gaviota, Mojoquin, and Yaca creeks in Santa Barbara County. Many other investigations into general sanitary conditions were carried on.

Highway Eating Places

Inspection of the following highway eating places and service stations were made during the month:

Number of eating places inspected and reinspected	61
Number found satisfactory	43
Number found with minor defects	13
Number found insanitary	5
Number of service stations inspected and reinspected	74
Number found satisfactory	56
Number found with minor defects	12
Number found insanitary	6

4. DIVISION OF LABORATORIES

Bacteriological Laboratory

Following is the diagnostic detail of examinations performed in this laboratory during May:

Slides prepared and examined for the diagnosis of diphtheria, tuberculosis, gonorrhea, malaria, rabies, culture identifications	4,064
Plate cultures made, examined and selected colonies transplanted during examination for typhoid, paratyphoid, dysentery, food poisoning, plague, unknown determinations, etc.	775
Culture tubes inoculated (fluid and solid media) for testing sugar reactions and other cultural characteristics during identification of unknown cultures isolated in blood, stool and food examinations and sent in by other laboratories	888
Animal inoculations for virulence tests, Kellogg tests, tuberculosis of kidneys, meningitis, standardizing vaccines, making immune serums, etc.	588
Precipitation tests, principally for syphilis	4,356
Complement fixation tests, principally for syphilis, but also for identification of cultures and immune serums	4,579
Agglutination tests, each one involving the making of eight different serum dilutions, centrifuging and examining; required for Widal tests for typhoid, undulant fever, typhus, tularemia and for identification of cultures, etc.	560
Total of procedures	15,810
Number of cases represented	5,963

Biologics

The following biologics were made in the laboratory and distributed during May:

Vaccine issued by the Bacteriological Laboratory during the month of May, 1937:	
Triplet typhoid	1,785 c.c.
Typhoid	4,560 c.c.
Agglutinating antigens:	
Typhoid	265 c.c.
Paratyphoid Alpha	230 c.c.
Paratyphoid Beta	210 c.c.
Br. Abortus	58 c.c.
Tularensis	4 c.c.

Antigen for diagnosis of syphilis:

Kolmer	130 c.c.
Kahn	820 c.c.
Kline	11 c.c.

Antisera:

Typhoid	4 c.c.
Paratyphoid Alpha	3 c.c.
Paratyphoid Beta	3 c.c.
Flexner dysentery	4 c.c.
H R Y dysentery	4 c.c.
Shiga dysentery	4 c.c.
Sonne dysentery	1 c.c.
Morgan	3 c.c.
Sulpestifer	1 c.c.
Dispar	1 c.c.
Aertrycke	1 c.c.
Enteritidis	2 c.c.
Strong	1 c.c.
Aerogenes	1 c.c.
Amboceptor	52 c.c.
Tubes of culture media	252

Ophthalmia neonatorum prophylactic outfits distributed during the month of May, 1937:

Number of ampoules.....5,636

Chemical Laboratory

During May, 106 official samples and twenty-seven unofficial samples of foods were examined in this laboratory. Of the official samples, forty-three were determined as illegal and of the unofficial samples, sixteen were found illegal—a total of fifty-nine out of 133 submitted. Most of these examinations covered carbonated beverages, dog foods, jams, jellies, and pickles. Four miscellaneous food products were examined for State institutions.

Water and Sewage Laboratory

During May, thirty-eight bacterial examinations and thirty-four chemical examinations of water were made in this laboratory; in addition, ten bacterial examinations of oysters were made.

5. FOOD AND DRUG INSPECTIONS

Egg Products

Many inspections of dried egg products were made during the month of May....

Dried Fruit

Inspections were made of packers of dried fruit in the San Joaquin Valley, particularly in Fresno, Kings, Tulare, Madera, Merced, and Stanislaus counties....

Used Containers

Inspections were made of plants using second-hand containers such as beverage manufacturers, vinegar and oil packers, relish and catsup packers, and retail wine bottlers. Steps were taken to improve methods of bottle washing in commercial plants.

"On-Sale" Inspections

A large number of inspectors have been assigned to the "on-sale" inspections. Menus and winery advertisements were found to be generally correct and stocks on hand agree with items listed. The most common violation is the substitution of domestic Scotch type whiskey for the foreign product. In some places, carbonated wine is used in "champagne cocktails." There have been fewer violations noted in "on-sale" establishments.

Inspection of "Barrel-Houses"

Inspections of "barrel-houses" show many owners as unfamiliar with label requirements on California wines. Efforts are made to correct this situation.

Food Products Destroyed

Because of their unfitness for human consumption, large quantities of wine, figs, and raisins were destroyed during May. Such destruction was accomplished only after every effort had been made to salvage the products for human consumption.

Prosecutions

Seven prosecutions were conducted in local courts. These covered wine, whiskey, and cognac. Convictions were secured in all but one case. Fines ranged from \$25 to \$500.

6. CANNERY INSPECTIONS

Tuna

A large tonnage of tuna was handled in packing plants during May....

Spinach

May brought the end of the spinach season.

Peas

The packing of peas is growing in popularity with the California packers and the acreage devoted to growing this product is considerably higher.

Artichokes

The commercial packing of artichokes seems to be growing in popularity, probably due to public demand for this product.

Asparagus

The month of May is a heavy packing season for asparagus. All canners have agreed to cease operations on June 20....

Summary

Among the food products packed under supervision of this bureau during May are the following: Animal food, artichokes, asparagus, beets, carrots, hominy, kidney beans, lima beans, mushrooms, olives, onions, peas, peas and carrots, pink beans, pork and beans, potatoes, puree, specialties, spinach, string beans, and vegetable salad.

7. TUBERCULOSIS

Activities of the Chief

The following institutions were inspected by the chief of this bureau during May: Maryknoll, Monrovia; Santa Terrisita; Los Angeles General Hospital; Weimar Sanatorium; Imperial County Hospital; San Diego County Hospital; Olive View Sanatorium; San Bernardino County Hospital; San Francisco Hospital, and Pasadena Preventorium.

8. CHILD HYGIENE

Activities of the Chief

A meeting was held with the southern section of the Professional Advisory Committee of the bureau at which the items on the proposed program for the Bureau of Child Hygiene during the coming fiscal year were discussed. A visit was made to the Mexican demonstration being conducted by this bureau in Southern California. Progress reports, statistical material and other reports were prepared during the month.

Pediatric Service

The pediatricians on the bureau staff conducted 203 conferences in forty-one counties during May. A total of 3,689 children were examined. In this group, 2,700 medical defects were discovered and referred to family physicians for correction. A total of 1,776 defects of hygiene were discussed with mothers. The medical staff vaccinated 193 children and immunized 412 against diphtheria. Pre-natal conferences were initiated in Humboldt, Placer, Santa Clara, and Santa Cruz counties.

Dental Service

A dentist was added to the bureau staff in April. During May, he made dental examinations in 1,673 children and gave educational talks before more than 1,300 children.

Nursing Service

The nursing service conducted by the bureau during May covered general and district supervision over the activities of migratory nurses, nurses working among Mexicans and those doing generalized service in the various counties. A large volume of work was accomplished by county nurses in Sierra, Calaveras, Modoc, Santa Barbara, Mariposa, Trinity, Lake, Kings, Tulare, Mono, Alpine, Lassen, Fresno, Madera, Imperial, and San Bernardino counties.

9. REGISTRATION OF NURSES

Activities of the Chief

Routine activities have been heavy for this season of the year. Schools of nursing were surveyed in San Francisco and Fresno. Addresses were given before pre-nursing students at the Fresno State College.

Activities of Inspectors

Most of the month has been devoted to making studies of facilities in teaching special diets in the various schools of nursing. Conferences were held at hospitals in San Francisco, San Jose, Alameda County and Stockton.

10. SANITARY ENGINEERING

The principal items of work of the engineers of the bureau, now numbering three, were a compilation of the utilization of sewage sludge; further work in a fluorin survey of wells in the Twenty-Nine Palms area; and one member of the staff has spent most of the month in attendance at a school in occupational hygiene in anticipation that such work may be undertaken in California.

The first item was a compilation of the utilization of sewage sludge in the two hundred or more sewage treatment plants in the State which produce sludge. The information is part of a nationwide canvass by an important committee of the American Public Health Association. The findings for California revealed that practically every city makes fertilizer use of its sludge, though only a comparatively small number carry on the use of the sludge on a business-like or profit-making basis, and none used sludge on vegetables.

Further work was done in a fluorin survey of wells in the Twenty-Nine Palms area, the result of which was the finding that the wells above a certain underground dike were the lowest in fluorin and the water could be used with comparative safety. Below this dike the wells take on a gradually increasing amount of fluorin and all the wells below the dike were seriously high in fluorin content. The subject is to be followed up further with a view to investigating possibilities of removing the fluorin by household devices.

A detailed report is as follows:

Sewage Disposal

New Projects

Orange County, which many years ago abandoned local disposal for a unified outfall to the ocean, driven to the scheme by nuisance from local sewer farms, is torn by debate over return to local disposal. There are eight large communities involved. It is a momentous decision. The bureau has been consulted in passing on the site proposed for local treatment at two of the places—Orange and Fullerton.

Placerville is about to vote on a bond issue for a long delayed cleanup of Hangtown Creek, which passes through the city and into which myriads of sewers have been emptying for generations. Healdsburg has voted bonds for a fairly comprehensive project which will abate a long standing case of stream pollution. It is understood that Napa is also looking into the possibility of such a project. The community of Newhall is also investigating a possible sewer system and sewage disposal and the bureau has been consulting with their local engineer in evolving the project.

Covina is reviving an effort to obtain a sewer system and sewage disposal and at the moment is considering building an elaborate sewage treatment plant underground in the city park and disposing of the highly clarified effluent through filter tiles laid deep in the natural soil. The bureau also conferred with the engineer at Murrietta Hot Springs and blocked out a scheme of sewage treatment for this resort. Advice was given the East Bay Recreational Department in a sewage treatment plant for its Wild Cat Canyon Camp. A scheme of improvements to sewage disposal was also discussed with the consulting engineer of the City of Needles. The bureau also advised the local citizens in the scheme of sewage disposal for an unincorporated area outside of Oroville and gave advice on procedure to organize a district. Big Bear Lake was investigated from the standpoint of the effect of high lake level on the scheme of sewage treatment should this area go ahead with a sewer system. Advice was given on a scheme of sewage disposal for a large subdivision in the vicinity of Lafayette. Conferences were held with the county health officer over a unified sewer system for Crockett. A site for disposal of wastes from a reduction plant was investigated at Brawley. Attended a conference with the City Council of Imperial over the elements of a sewage treatment plant which might avoid necessity of a long sewer to New River. Basis of design for sewage trickling filter for Stockton State Farm was discussed with the State architect.

Advice was given the State Park Commission in the matter of temporary improvements to sewage disposal at Big Basin which would fit into a permanent construction which it is expected may be undertaken within the next year. Advice was also given in sewage disposal of a large roadside place at Grapevine on the Ridge Route. Application for permit has been received from Orange for the construction of an activated sludge plant on San Gabriel River; also from the City of Hemet to dispose of sewage for irrigation in the vicinity of the sewer farm.

Plans were reviewed for a sewer outfall for a new trickling filter plant at Modesto and at Imhoff tank with various types of disposal for resettlement camps at Winters, Marysville, Shafter, Coachella, and Arvin. New sewage treatment plant recently completed at Stockton was inspected.

Complaints

Complaints were received against overflowing cesspools at Hemet and request for help in improving sanitation in San Lorenzo River. A complaint was received also from the water company at Coronado against the location of the proposed sewer from Tiajuana which would pass somewhere near the wells.

It is understood that on account of the introduction of a new cracking plant for gasoline in the Santa Fe oil fields, there has been an extensive odor nuisance along the drain line from this oil field to the ocean. However, complaints have not reached this department.

Special Mention

The beach at Monterey was inspected from the standpoint of noting the cleanup accomplished by the removal of the city sewer from its old location to another one nearly a mile away. It was observed that there is still faeces on the beach though not to the extent as formerly, probably due to toilets on the small boats in the harbor or possibly to toilets on the wharves, and the beach was badly littered with garbage-like refuse, broken glass and flotsam brought in by the tides. The beach at Carmel was also inspected. Here the sewage, once retained in tanks and discharged periodically, is allowed to spew onto the beach continuously. This particular beach is not used to great extent but on the date of inspection, several parties were picnicking there.

These are the first of numerous inspections the bureau expects to undertake in the next year or so in order to comply with a request from the State Assembly for a report on instances of beach and stream pollution up and down the State.

An interesting meeting was attended in which the subject of mountain sanitation in Los Angeles County was discussed by the county health department. Hundreds of analyses of water were made on the streams and it is encouraging to note that in spite of the tremendous increase in the crowds flocking to the mountains, the analytical evidence is that pollution is held down so that there is little difference between streams above the recreational area and points on the stream below. The accomplishment is clearly the work of endless preaching and education of recreationists in behalf of conserving the streams against pollution.

Water

New Projects

Antioch is about to add some additional filters and has discussed with the bureau the elimination of cross-connections which would admit raw water into the filtered water system. Various conferences have been held with the State engineer's office over new water supply for Napa State Hospital and Veterans Home; also with the Highway Department over improvements to their well supply at Marysville headquarters. An inquiry was received from Beverly Hills over approving certain reservoir improvements in accordance with the requirement of the Public Works Administration.

Complaints

Considerable time was spent in an effort to adjust complaints by the City Health Department of Los Angeles against the city water supply. A case of resort pollution of White Water River at the headworks of the Palm Springs irrigation system was investigated with the county health officer and various procedures blocked out, one

depending on an attempt to clean up the sanitation at the resort and the other utilizing the river sands for artificial improvement of the water.

Certain wells in Eldorado County were investigated in connection with the occurrence of jaundice epidemic in a school, and conclusion pretty well reached that the trouble was due to mice and rats which fell into the water.

Special Mention

A problem over water supply for the Resettlement Camp at Brawley has been solved by an agreement to compensate the city in an amount which will build an additional filter at the city waterworks and supply filtered water instead of simply settled water to this camp. The water supply in Palm Springs was investigated in connection with the complaint against conditions on White Water River. A perplexing problem has been raised by the San Francisco Water Department over the matter of various cross-connections within hotels and office buildings. The situation became noticeable in connection with the recent hotel employees strike in which new workmen came on, not familiar with the hotel piping, and, of course, wrong manipulation of the valves was a serious threat to the purity of the drinking water.

Conference was held with the engineers for the San Francisco Exposition over the avoidance of proposed cross-connection with bay waters for fire fighting purposes. The investigation into fluorids in the Twenty-Nine Palms area has already been referred to. The water supply at Oasis was resampled and inspected in connection with certification as analyses indicate that pollution is going on somewhere.

Mosquitoes

A visit was made to San Mateo County and South San Francisco in connection with mosquito abatement.

Shellfish

Oyster beds in Tomales Bay were investigated in connection with a recent quarantine, by the San Francisco Health Department, of oysters from several miles of bay shore, seemingly of virgin purity. The findings were confirmed that in certain parts of the bed the oysters are pretty badly affected with *Staphylococcus aureus* and the oysters, though not spoiled, are decidedly unfit for food. Other oyster beds in which the taking of oysters was stopped last winter, were reinspected and resampled with a view to lifting the restriction. The watershed of Drakes Bay was also gone over thoroughly, seeking out pollution that might affect extensive layings in Drakes Bay. The City Health Department of San Francisco has also quarantined clams from an area in Sobra. Investigations were started to try to clear up this situation.

Swimming Pools

Numerous inquiries continue to be received almost every day for information and literature on swimming pools. A conference was held over trying to raise the standards of swimming places in Contra Costa County. Help was also given the Berkeley Women's City Club on account of excess chlorin.

Laboratory

On routine samples run in the laboratory, opinions were rendered on thirty-eight samples analyzed for bacteria and thirty-four samples for chemical tests involving 271 determinations, and ten samples of oysters involving forty determinations.

11. VITAL STATISTICS

Marriage Increase

The first three months of 1937 show increased numbers of marriages over a corresponding period of last year. Following is the statistical detail:

	1936	1937
Total—first three months.....	12,218	12,836
January	4,201	4,409
February	4,058	4,000
March	3,959	4,427

Births

There were 633 more births registered in the State during January of 1937 than in January of 1936. In the first month of the present year, there were 7,212 births recorded while during the corresponding month of last year, there were 6,579 such events registered.

CAN COUNTY MEDICAL SOCIETIES DISCIPLINE MEMBERS?

A decision recently handed down by the Supreme Court of the State of Washington has been much discussed and is given below for readers who are interested in the principles involved:

Porter et al., vs. King County Medical Society et al.

No. 25862

SUPREME COURT OF WASHINGTON

[1] Trade-marks and trade-names and unfair competition.—Employee has no right of action against employer's competitor engaging in same business by using same means as employer.

[2] Master and servant.—Business manager employed by physicians operating clinic held to have no cause of action against medical society or competing clinic organized by such society because defendants employed former clinic's best solicitor; solicitor having been employed under terminable contract.

[3] Physicians and surgeons.—Incorporated medical society's constitution, charter, and by-laws held to constitute contract between members enforceable by courts unless immoral or contrary to law or public policy; selfishness of society's objects being immaterial if legitimate.

[4] Physicians and surgeons.—Medical society held entitled to adopt by-law warranting expulsion of members unauthorizedly operating clinics or engaging in group contract practice; whether by-law was just, reasonable, or wise being question of policy concerning only society and its members.

[5] Physicians and surgeons.—Medical society in enforcing by-laws for direct purpose of benefit to itself and members held not answerable for damage incidentally resulting to third person.

[6] Physicians and surgeons.—Members of medical society held bound to obey its laws, rules, and regulations or be fined, suspended, or expelled.

[7] Master and servant.—Business manager of clinic employed for unlimited term by physicians who, to avoid expulsion from medical society pursuant to by-law, were compelled to abandon their clinical and group contract practice held to have no cause of action for damages against society or its competing clinic.

Department Two.

Appeal from Superior Court, King County; J. T. Ronald, Judge.

Action by Frank G. Porter and others against the King County Medical Society, a corporation, and others. From a judgment of dismissal, plaintiffs appeal.

Affirmed.

Charles H. Graves, of Seattle, for appellants.

Charles F. Riddell, of Seattle, for respondents.

MILLARD, Chief Justice.

This action was instituted against the King County Medical Society, a corporation, the King County Medical Service Corporation, and certain officers, trustees, and members of the two corporations to recover damages alleged to have been sustained by the plaintiffs by reason of defendants having induced Doctors Ralph L. Sweet and Goff MacKinnon, members of the King County Medical Society, copartners, who were doing business as the Associated Physicians Clinic, to breach a contract existing between the plaintiffs and the copartnership.

The appeal is from the judgment of dismissal rendered upon the plaintiff's refusal to plead further after a demurrer had been sustained to the complaint, upon the ground that the same failed to state facts sufficient to constitute a cause of action.

The allegations of the complaint are summarized as follows:

The King County Medical Society, a domestic corporation, is one of the constituent societies of the Washington State Medical Association, which in turn is one of the constituent societies of the American Medical Association. The King County Medical Service Corporation is a subsidiary of the King County Medical Society. The individual respondents, physicians and surgeons of Seattle, are officers, trustees, and members of either one or both the King County Medical Society and the King County Medical Service Corporation. The major portion of the practicing physicians and surgeons of King County are members of the King County Medical Society. That society, through its affiliation with the various county associations and State associations, virtually dictates and controls the policies of the medical profession and its functions and practices in

King County and dominates and controls all the accredited hospitals in King County. The King County Medical Society, through the power of its organization and activities, has created for its members a virtual monopoly of the medical profession and practice in King County, and has thereby established for its members an exorbitant schedule of fees and charges which are exacted from those requiring medical and hospital treatment. The society dominates and controls the individual business affairs and professional practice of its own members, and by threats of expulsion and other similar methods it infringes upon the right of its members to conduct their own affairs and profession as they see fit.

Within the last twelve years, individual physicians and a few groups of physicians, all active members of the King County Medical Society, organized, independently of the society, " * * * 'group medical service clinics' whereby groups of individuals and employees * * * enter into specific contracts with said clinics whereby upon payment of nominal monthly dues or fees, they are entitled to receive and do receive all necessary medical, surgical, and hospital care and treatment in case of sickness or disability. * * * "

Among the clinics thus organized in King County was the Associated Physicians Clinic, organized about twelve years ago by Doctors Sweet and MacKinnon, members in good standing of the King County Medical Society. Until September 1, 1934, these two physicians were engaged in the group medical contract practice through contracts with many large business firms of Seattle, "whereunder they furnished medical and surgical care and hospitalization to a large number of employees of such firms at the rate of one dollar per month per capita, and that virtually all of said contracts were secured for the said Associated Physicians Clinic by the plaintiff, Frank G. Porter, as particularly hereinafter set forth."

Approximately six years ago, Doctors Sweet and MacKinnon, by a written contract for an unlimited term with Frank G. Porter, employed him "as manager of their contract department to conduct generally the business end of the said clinic, particularly in securing new medical contracts for the same, to make collections of all monthly fees or dues thereunder, to furnish and maintain first-aid kits for all firms and companies under contract, to service and maintain all of said group contracts and to adjust all complaints or disagreements that might arise concerning the same; that in consideration for his said services, said agreement provided that the plaintiff, Frank G. Porter, should have and receive a sum equal to twenty-five per cent (25%) of all gross sums received upon said group service contracts; the balance thereof or seventy-five per cent (75%) of the gross going to said Associated Physicians Clinic."

At all times since the organization of such independent clinics as the one organized by Doctors Sweet and MacKinnon, the individual respondents and the King County Medical Society and a majority of its members "have been opposed to such group contract practice, in that it tended to injure the monopoly enjoyed by the society and its members in the medical profession and practice, and tended to deprive members of the society of much of their exorbitant and excessive fee practice."

About two years ago the respondents entered upon a definite, concerted campaign to destroy such contract practice, and began to harass all of said clinics on the ground that such practice was unethical. The respondents demanded that Doctors Sweet and MacKinnon and other physicians engaged in such practice abandon same. In September, 1934, Doctors Sweet and MacKinnon and the other physicians engaged in such practice were forced to abandon the same as the direct result of a conspiracy by the respondents, "all as particularly hereinafter set forth."

In order to accomplish their purpose, the King County Medical Society and the other respondents proceeded as follows:

(1) The King County Medical Society organized its own group clinic on April 7, 1933, under the corporate name of the King County Medical Service Corporation. This clinic was in all respects identical in its plan and operation with that of the Associated Physicians Clinic and the other independent clinics.

(2) The respondents employed and took away from appellants their oldest and most experienced assistant, who was familiar with all of appellants' records and with all of the then existing contracts which appellant's husband had secured for the Associated Physicians Clinic pursuant to his agreement with that clinic. This assistant, in the employ of the respondent King County Medical Service Corporation, with such knowledge of the business of the Associated Physicians Clinic, solicited the firms and companies which appellant Porter had placed under contract with the Associated Physicians Clinic and succeeded in inducing many

of such contract holders to withdraw from their contracts and take new and similar contracts with the King County Medical Service Corporation.

(3) On August 7, 1933, the respondents procured the adoption by the King County Medical Society of an amendment to the by-laws which amendment is marked Exhibit A and attached to the complaint. The amendment provides that all charges against a member of the King County Medical Society shall be made in writing to the board of trustees. The charges shall be investigated by the board at its discretion. The accused shall be given the privilege of a hearing before the board, and if the charges are found to be of sufficient moment, the charges shall, at the discretion of the board, be reported to the society with a recommendation for action. The by-law then provides:

"A member who has been found guilty of a criminal offense or of gross misconduct, either as a physician or as a citizen; or whose license to practice medicine in this state has been revoked or suspended by the State Board of Examiners; or who has committed any act which may be derogatory to the medical profession; or who shall refuse or neglect to obey the regulations of this society, or who knowingly gives false testimony as an ordinary or expert witness; or who has violated any of the provisions of these by-laws; or who shall violate the code of ethics of the American Medical Association as the same is now written, or as it may hereafter be changed; or who shall be guilty of any disloyal, seditious or treasonable utterance, writing or act against the United States, or who shall engage in contract practice unless the same shall previously have been authorized by the Board of Trustees of this Society, or who as physician or surgeon shall serve on the staff of or perform work for the patients of, or shall perform work in any institution or group or organization unless such services or work shall previously have been authorized by the Board of Trustees of this Society, shall be liable to censure, suspension or expulsion. Censure, suspension or expulsion shall require a two-thirds affirmative vote of the members present and voting at a regular meeting. Written notice of the charges preferred must be given to the accused, and to each member of the society, ten days in advance of such meeting. Opportunity for the accused to be heard in his own defense shall be given before a vote of the Society is taken on his censure, suspension or expulsion."

"A member under suspension may be reinstated to active membership by a two-thirds affirmative vote of members present and voting at a regular meeting."

(4) Soon after the passage of the aforesaid amendment to the by-laws, the society threatened the expulsion of Doctors Sweet and MacKinnon unless they abandoned their contract practice, including their contract with appellant Porter, as well as all contracts covering their group service with their patients. The society further demanded of the two doctors that they surrender and turn over to the society and to its subsidiary clinic, the King County Medical Corporation, all of their books and records in connection with their said contract practice as the Associated Physicians Clinic, "all of which Doctors Sweet and MacKinnon, at first, failed and refused to do."

(5) On March 19, 1934, respondent Arthur C. Crookall, a leading member of the King County Medical Society, filed written charges, signed by thirty members of the medical society, "charging said Doctors Sweet and MacKinnon with unethical conduct under said by-law's amendment, on account of their continuing to engage in a medical service contract practice not authorized by the Board of Trustees of said Society, in defiance of the said by-law amendment, and which resolution demanded that the Board of Trustees of the society carry out the necessary action to deprive Doctors Sweet and MacKinnon of membership in the society and urgently requesting said trustees to take prompt and drastic action against said physicians Sweet and MacKinnon without compromise; a true copy of which resolution is herewith attached, marked Exhibit 'B' and made a part of this complaint. That said resolution was adopted and approved by said society, and thereupon the defendants served upon Doctors Sweet and MacKinnon notice of the charges against them and the terms of said resolution, and then cited said physicians to appear before the society to show cause, if any they had, why they should not be expelled from membership in said society."

By reason of the filing of the charges and because of the action it was known the respondent medical society would take against them, Doctors Sweet and MacKinnon, on September 1, 1934, abandoned their contract with appellant Porter.

At the commencement of appellant Porter's services with Doctors Sweet and MacKinnon, the volume of their contract practice was relatively small. During the ensuing six years, the appellant Porter, through his service, industry, and organization, increased and built up the contract practice of the Associated Physicians Clinic to large proportions.

" * * * That at the beginning of the wrongful attacks upon said clinic by the defendants, as aforesaid, he had increased its practice to the extent of having approximately one hundred firms or companies under contract therewith and was servicing in excess of two thousand of their employees, yielding a gross sum or revenue of over two thousand dollars (\$2,000.00) per month, one fourth of which being received by the plaintiff under and by virtue of his said contract; that by reason thereof and a result of his own labor and industry, as aforesaid he had created in and given to his said contract a high and lasting value, as well as making same correspondingly valuable to Doctors Sweet and MacKinnon, and which, but for the wrongful acts of the defendants, as hereinbefore stated, would have become increasingly valuable to plaintiff for many years to come."

[1] We do not understand that appellants seriously contend that the organization of the King County Medical Service Corporation by the King County Medical Society as a competitor of the Associated Physicians Clinic would constitute a cause of action against the respondent corporations and the other respondents who are officers and members of the two corporations. An employee has no right of action against an individual or a group of individuals who organize to compete with his employer and to engage in the same business by the use of the same means which his employer uses.

[2] We agree with counsel for respondents that the only ones (if any one may) who may complain of the competition of respondents with the business of Doctors Sweet and MacKinnon are the doctors named. Appellants have no cause of action against respondents because the latter employed appellants' best solicitor. Appellants' solicitor was employed under a terminable contract. That being so, the employment of that solicitor by respondents does not constitute a cause of action in favor of appellants. *J. J. Case Threshing Machine Company vs. Fisher & Aney*, 144 Iowa, 45, 122 N. W. 575.

[3-6] It is unnecessary to discuss the question of whether the character of the medical contract service is ethical or unethical. Doctors Sweet and MacKinnon were members of the medical society twelve years ago and have been continuously members ever since that time. The constitution, charter, and by-laws of the medical society constitute a contract between the members of the society which the courts will enforce if not immoral or contrary to public policy or the law of the land. (16 R. C. L. 422.) That is to say, Doctors Sweet and MacKinnon, under their contract with the medical society, were required to obey the by-laws of the society or by breach thereof subject themselves to the penalty of suspension or expulsion from the society. It is not at all material how selfish or unselfish the objects of the medical society are if same are legitimate. It cannot be successfully contended that the medical society did not have the right to adopt the by-law in question. Whether such by-law or rule was just, reasonable, or wise is a question of policy which concerns only the medical society and its members. The medical society, in the enforcement of its by-laws for the direct purpose of benefit to itself and to its members, is not answerable for damage incidentally resulting to a third person. So long as one remains a member of the medical society, such member can be compelled under his contract with the society to obey the laws, rules and regulations of the society or suffer the penalty of fine, suspension, or expulsion. The rule that the enforcement of a by-law such as the one involved in the case at bar does not constitute coercion is sustained in *Seymour Ruff & Sons, Inc., vs. Bricklayers, etc., Union*, 163 Md. 687, 164 A. 752, 757, where the court said:

"Whether an order of a union directing its members not to serve a particular employer is lawful is discussed in 16 R. C. L. 448, where it is said: 'In a number of decisions the question has been raised whether it is lawful for a labor union to order its employees not to serve a particular employer. One court has reached the conclusion that the imposition of fines upon members of a labor union to compel them to join a strike has the effect of intimidating such persons and is therefore unlawful. (*L. D. Willcutt, etc., Company vs. Driscoll*, 200 Mass. 110, 85 N. E. 897, 23 L.R.A. (N.S.) 1236.) But this conclusion is opposed to practically all of the decisions on the subject. The decisions are practically in harmony in holding that it is within the power of labor unions, and it is lawful for them, to instruct or order their members not to accept employment with an individual, or to continue in such person's employment, where the action of a union is justifiable in the sense that it is to promote the welfare of the members of the union. Accordingly, the enforcing of a by-law forbidding members of the union to serve one who has broken a contract with its members does not amount to intimidation. Neither a fine or other disciplinary action under such by-law would be unlawful as to members who voluntarily subject them-

selves to the provision of such by-law. They are left free to enter the employment of the prescribed employer, although practically they are compelled to choose between the benefits of such employment and membership in the union. (*Rhodes Bros. Company vs. Musicians' Protective Union Local No. 198, etc.*, 37 R. I. 281, 92 A. 641, L. R. A. 1915E, 1037 and notes.) Similarly, it has been decided that a labor union may lawfully order its members not to work on premises where work is being done by employers who are deemed to be unfair to union labor.'

"This question was also discussed in *McCarter vs. Baltimore Chamber of Commerce*, 126 Md. 131, 94 A. 541, 543, where reference was made to *Bohn Manufacturing Company vs. Hollis*, supra [54 Minn. 223, 55 N. W. 1119, 21 L.R.A. 337, 40 Am. St. Rep. 319], the facts of which were reviewed and the finding of the court approved in *Klingel's Pharmacy vs. Sharpe & Dohme*, supra [104 Md. 218, 64 A. 1029, 7 L. R. A. (N.S.) 976, 118 Am. St. Rep. 399, 9 Ann. Cas. 1184]. On the question as to whether the by-law providing for expulsion was coercive, the court said: 'But this involved no element of "coercion" or "intimidation," in the legal sense of those terms. * * * Nor was any coercion proposed to be brought to bear on the members of the association, to prevent them from trading with the plaintiff. After they received the notices, they would be at entire liberty to trade with plaintiff, or not, as they saw fit. By the provisions of the by-laws, if they traded with the plaintiff, they were liable to be "expelled"; but this simply meant to cease to be members. It was wholly a matter of their own free choice which they preferred—to trade with the plaintiff, or to continue members of the association.'"

In *Bohn Manufacturing Company vs. Hollis*, 54 Minn. 223, 55 N. W. 1119, 1120, 21 L. R. A. 337, 40 Am. St. Rep. 319, in which an association of lumber dealers was sued for incidental injury resulting to a third person, the court said: "They agree among themselves that they will not deal with any wholesale dealer or manufacturer who sells directly to customers, not dealers, at a point where a member of the association is doing business, and provide for notice being given to all their members whenever a wholesale dealer or manufacturer makes any such sale. That is the head and front of defendants' offense. * * * Nor was any coercion proposed to be brought to bear on the members of the association, to prevent them from trading with the plaintiff. After they received the notices, they would be at entire liberty to trade with plaintiff, or not, as they saw fit. By the provisions of the by-laws, if they traded with the plaintiff, they were liable to be 'expelled'; but this simply meant to cease to be members. It was wholly a matter of their own free choice, which they preferred—to trade with the plaintiff, or to continue members of the association."

To the same effect is *Booker & Kinnaird vs. Louisville Board of Fire Underwriters*, 188 Ky. 771, 224 S. W. 451, 454, 21 A. L. R. 531. That involved a case where an association of insurance men prohibited members from representing more than one company. The by-law was enforced and the offending company expelled. Its business was ruined. Whereupon it instituted an unsuccessful suit against the association. In the opinion in that case the court said:

"In other words, these by-laws oblige members of the board to confine their insurance business to companies who have board agents, and forbid members to give to or accept insurance business from non-board agents and thereby limit the business rights that agents who are members of the board might exercise if they were not members. * * *

"In almost every profession and every business there are associations or lodges or boards, organized by persons engaged in particular lines of industry or following certain professions, that have for their sole purpose the protection and promotion of the best interest of the business or profession in which they are engaged. And bodies like these, acting in a collective capacity, may, in a quiet orderly way when their interests demand it, refuse to deal with or have any business relations with any other person or persons they choose, although the effect of such combined action is to boycott the objectionable person, very much in the same way as the boycott put into effect in this case against Booker & Kinnaird.

"But this character of boycott does not fall under the condemnation of the law. If it did, no persons acting in concert for their own benefit could refuse to have business relations with or terminate their existing business relations with persons they have theretofore transacted business with. * * *

"Booker & Kinnaird have preferred to remain outside of the board and compete with its members, while at the same time insisting that the members shall resume business relations with them. In brief, it would appear that Booker & Kinnaird want to force the board members to renounce the board rules and regulations and deal with them, while the board members prefer to stand together and have no

business relations with Booker & Kinnaird. As I look at it, each of the parties is within their legal rights—one, in refusing to leave the board; the other, in refusing to return to it—and neither has any legal cause for complaint against the other. * * * The further effect would be to take from the members the right to expel any member who refused to observe the by-laws of the board, and the inevitable effect of all this would be the destruction of the board in so far as its usefulness as a business organization was concerned."

In *Cohn & Roth Electric Company vs. Bricklayers', etc., Local Union No. 1*, 92 Conn. 161, 101 A. 659, 660, 6 A.L.R. 887, the Supreme Court of Errors of Connecticut announced the rule as follows:

"These by-laws create an agreement on the part of these several unions and all of their members, binding upon them, that their members will not work for any employer employing nonunion men on that job, nor for any nonunion contractor, nor on any job sublet to any contractor by any open shop or nonunion contractor. Interpreted together, these several by-laws constitute an agreement, which membership imposed upon all members of defendant unions, that they would not work on any job on which nonunion men or employers are at work.

"All members of defendant unions have ceased to work and refused to work on any building when the nonunion employees of the plaintiff have commenced work on such building. * * *

"The end the defendants had in view by their by-laws was the strengthening of their unions. That was a legitimate end. There is no indication that the real purpose of the defendants was injury to the plaintiff, or the nonunion men it employed. Whatever injury was done the plaintiff was a consequence of trade competition, and an incident to a course of conduct by the defendants, begun and prosecuted for their own legitimate interests. The means adopted were lawful; no unlawful compulsion in act or word was present."

[7] The weight of authority is to the effect that in pursuing its legitimate objects an association has the right to coerce a member by fine, suspension, or expulsion, and the association will not, nor will its members be, liable in damages to those who may be directly or indirectly injured by such efforts. So long as a member remains in the association, he is subject to the coercive effect of a penalty exacted for breach of a by-law of the association. If he does not desire to abide by the obligations of his contract of membership, he may abandon his membership. No right of appellants, who were nonmembers, was invaded by respondent medical society when it established its code of ethics and insisted upon compliance therewith through threat of expulsion of an offending member. We agree with counsel for respondents that, viewed as an association engaged in promoting the interests of its membership, the enforcement of solidarity by threat of expulsion of one of its own members creates no cause of action for the incidental damage resulting to an employee of that member who has a contract of employment "for an unlimited term."

The judgment is affirmed.

Blake, Main, Holcomb, and Beals, JJ., concur.

PRESS CLIPPINGS

The daily press frequently print items having a direct or indirect relationship to medical practice. In the current issue some of these are given space for the information of readers.

Government Medicine

This momentous thing of putting the Federal Government into the medical field, now brought to a head by the President's direct proposals to the American Medical Association, is not going to be solved by any one simple prescription. The eventual remedy for maladjustment of medical facilities in this country will have to be worked out by joint consultation of the doctor, the patient and governing officials.

Physicians as a group, naturally, rebel at the idea of federalized medicine in any form. The more successful they are, the more they rebel. They contend that after the rigorous training required of a modern doctor he should not be regimented, like a worker in a pick-and-shovel relief gang, for government service.

The patient, too, despite the fact that he may at times lament the costs of a private physician, is loath in most cases to intrust himself and his family to the care of some salaried public doctor who he feels may not be as interested in his work as the private physician.

It is obvious, on the other hand, that the requirements of modern society for organized medical care are growing

tremendously. County and city hospitals are taxed with the care of emergency cases that cannot, in common humanity, be rejected. There undoubtedly is something to the argument that this overflowing burden is becoming a concern of federal agencies.

The imperative requirement is that the solution be worked out so that neither the patient nor the physician will suffer an injustice. Senator Lewis in his reputedly blunt demand upon the Medical Association to consider itself as a government official smacks too strongly of ill-considered regimentation of the worst kind. Doctors cannot be ordered arbitrarily into federal service with any expectation of benefit to anybody.

Some development of the clinic idea, with rigid supervision by the Medical Association itself, may be the eventual solution. The poor must not be neglected. But they will not be aided by any policy which makes their doctors virtual "yes men" of political superiors.—Editorial, *Los Angeles Times*.

Charities Give Aid to Many

Total of 225,000 Get Help in County During Fiscal Year

Food, shelter and medical treatment were furnished to more than 225,000 residents of Los Angeles County by the County Department of Charities during the fiscal year ending June 30 last, according to a report on file yesterday in the office of Rex Thomson, superintendent of the county's welfare activities.

Major Divisions

The figures of the four major divisions of the department are as follows:

Bureau of indigent relief: Assistance provided 77,243 cases, representing approximately 154,000 individuals.

General Hospital: Medical treatment provided for 67,187 patients acutely ill.

County Farm: Medical treatment and ward care given 4,479 inmates incapacitated by chronic ailments and advanced age.

Olive View Sanatorium: Surgical treatment and ward care given 1,731 patients suffering from tuberculosis.

Cases Increase

The report from the bureau of indigent relief discloses an increase of 19.3 per cent in the case load because of the number of persons receiving aged and blind aid. This increase is largely due to the liberalization of the old age pension laws by the State Legislature.

More than 35,000 applications for aged and blind aid were received in two years. All were investigated by the bureau of indigent relief as required by the law.

During 1935-1936 a total of 8,645 cases were forwarded to the Board of Supervisors for approval. In the last twelve months this figure was increased to 17,419. At the end of the fiscal year only 3,300 applications remained incomplete, according to the report.

\$87.50 Aid Cost Per Capita

516,440 Relief Clients Here Last Year

In 1925, indigent and unemployed relief costs in Los Angeles County were 92 cents per capita of taxpayers.

Now the cost is \$87.50 per capita of taxpayers.

And, in a twelve months' period just ended, 2,046,614 persons—a large proportion of them indigent—flocked into California.

Rex Thomson, superintendent of charities, revealed this appalling situation in a report yesterday.

516,440 on Relief

For the year surveyed, ending last April 30, there were 516,440 persons in the county receiving relief of some kind from national, state, or county sources, he stated. This is equivalent of 19.36 per cent of the entire population here.

The percentage of relievers dropped slightly less than 4 per cent below the totals for the preceding twelve months' period, but relief costs jumped \$29.37 per taxpayer for the period, he declared.

Plea for U. S. Aid

Harry L. Hopkins, federal administrator, yesterday was given these figures in Washington by Thomson in conjunction with the county's urgent plea for major federal and state assistance in carrying the growing local relief load.

Influx of unemployed transients has grown alarmingly in recent months, Thomson's report showed. No figures were available to reveal the percentage of those coming here who are without means to support themselves, the State Department of Agriculture reported. Of the total of

2,046,614 persons who entered California during the twelve months' period ending April 30, 74 per cent indicated they were bound for Southern California areas, the report declared.—*Los Angeles Examiner*, July 10, 1937.

Ills of Labor Migrant Told*

Perkins Report Cites Bad Condition of Transient Workers

Secretary Perkins told the Senate today millions of American workmen and their families move around the country in search of jobs, without adequate direction and often living under "deplorable" conditions.

A certain amount of this labor migration is necessary to take care of industrial changes and seasonal work such as harvesting, Miss Perkins added in a report on migratory workers the Senate ordered last year.

Forced to Move

"Increasing numbers of workers are forced to move ceaselessly across state lines to eke out a living by piecing together short and scattered seasons of employment in agriculture and industry," she said.

"As long as employers demand much more labor in one season than another, workers must migrate or find some alternative means of subsistence within each local area.

"Migration of workers, although necessary, is largely unguided or ill-directed. Although the relocation of workers has been broadly advantageous, it has often been inefficient from the point of view of the particular individuals involved.

Jobs Not Assured

"Rarely does any type of migrant have the assurance of a definite job until after he has moved. The lack of such assurance is especially disastrous for seasonal migrants who hope at most to share in a few weeks of employment in one place.

"When the migration of seasonal workers is overstimulated, untold misery results.

"Seasonal migrants in agriculture seem to be able to average only about six months of work each year. They appear to average about \$300 a year per single man and \$400 a year per family.

"The migrant and his family tend to be isolated from the normal activities of the community, both because of their enforced mode of travel and living and because of community prejudices against them.

Living Conditions Bad

"Living conditions for most migrants are deplorable. Families with as many as six children are traveling in old cars and trucks. At night they sleep by the roadside, in squatter camps or crowd into one or two-room cabins in low-priced tourist camps.

"Children old enough to work in the fields are expected to contribute badly needed income, and parents often do not consider it worth while to enroll the younger children in school during their short stay in any one community."

Miss Perkins emphasized that her report was incomplete because of lack of funds for a comprehensive survey. She said recommendations for legislation might come after a more complete study of the problem is made.—*Los Angeles Times*, July 4, 1937.

Migratory Jungles

A "cleanup" of hobo camp "jungles" in Los Angeles County was ordered today by the Board of Supervisors as the first step in combating the growing cost to public charity of transient indigents flocking into California from the East.

The cleanup was ordered coincident with the policy enunciated by Supervisor Herbert C. Legg upon his return from a transient relief conference in San Bernardino yesterday, when he said that "jobs in California must be for California citizens."

Chairman Roger Jessup of the supervisors here instructed Sheriff Eugene Biscalluz today to call a meeting of the chiefs of police in the forty-four municipalities in Los Angeles County immediately to outline a course of action to clean up the hobo camps. He also recommended auto camps be checked thoroughly.

"The indigent problem in Los Angeles County is terrific and the moron element infesting this county is a big danger to respectable citizens," Jessup declared.

Indicating the growing cost to taxpayers of supporting indigents from other states who are arriving in California at the rate of 3,000 to 10,000 a month, Jessup revealed the tentative budget for the charity department of the county this fiscal year is \$21,591,000, compared with \$13,810,000 during the last fiscal year.

Supervisor Legg conferred in San Bernardino yesterday with C. E. Grier, supervisor of that county and president

* See also pages 74 and 131.

of the California Supervisors' Association. San Bernardino has refused to give relief to indigent transients, despite a ruling by Attorney General U. S. Webb that counties must care for such transients. Los Angeles County has been caring for this class of indigents.

"Figures show 35 per cent of those applying to the unemployment service for work in California are nonresidents," Legg said. "I am urging a policy that jobs in California, relief or otherwise, must go to citizens."

It is planned to contest Webb's ruling, Legg said, because many feel transient relief is a responsibility of the state and federal governments. Mayor Frank L. Shaw of Los Angeles last week stated similar convictions to the city council in urging that the Federal Government assume this burden.

Supervisors will confer with Governor Frank Merriam in Los Angeles, probably Tuesday, to arrange a meeting of state and county officials to try to solve the indigent relief problem. Should this not prove productive, the Supervisors Association will take action, it was stated.—*Los Angeles Evening Herald-Express*, July 16, 1937.

Senate Aids Cancer Study

Passes \$700,000 Bill for Research

Washington, July 22.—The Senate passed and sent to the House today a bill authorizing expenditure of \$700,000, to advance cancer research.

The measure would create in the public health service a national cancer institute to conduct and assist studies of the cause, prevention, and treatment of cancer.

Cancer research of other agencies would be coordinated under the health service. An advisory committee of medical authorities would be set up to aid in carrying out the bill's provisions.—*Los Angeles Examiner*.

Health Act Befogs British Columbia

Plebiscite Over Legislature's Compulsory Insurance Law Only Adds to Confusion

Issue on Ballot Vague: Medical Men Revolted Over Fees Set by Board and Future of The Scheme Is in Doubt

Victoria, B. C., July 3.—This capital city of British Columbia is bewildered. The government's health insurance chicken has come home to roost, and nobody seems to have any idea what to do with it.

For many years health insurance has been discussed, but last year the government of T. D. Pattullo introduced a bill in the Legislature vaguely outlining a scheme of compulsory contributory health insurance. The measure passed in the House by a narrow majority, with the aid of the Socialist section of the opposition.

Immediately George M. Weir, Provincial Secretary, under whose department the administration of the Health Insurance Law falls, made preparations for its enforcement.

Doctor Weir leased a five-story building and hired an army of statisticians and insurance experts. They went to work with a will to frame a suitable set of regulations, the act having left details to the organization that was to be created.

The main features of the regulations were: (1) Only employed persons earning \$1,800 or less, with their families, were included; (2) indigents, casual labor, farmers, domestics, trappers, fishermen having their own boats, prospectors and a host of other classes, including those working for themselves, were excluded, as well as all suffering from tuberculosis and social diseases; (3) services were announced as "mandatory" and "permissive" benefits, the latter dependent upon funds being available at some future date.

The Mandatory Benefits

The mandatory benefits included: Services of a physician, the first call to be paid for by the patient at the rate of \$1 if made by day and \$1.50 at night; maternity care; hospital service in a public ward for a period not to exceed ten weeks; necessary drugs, medicines, and dressings subject to the provision that the insured might be required to pay up to one-half the cost of these items, and full laboratory service and diagnostic aids, including x-ray, biochemical, and other services.

The announced plan for financing the scheme was by compulsory deduction of 2 per cent of the wages of employed persons coming under its provisions, while the employer was ordered to contribute 1 per cent. The employee was to pay a minimum of thirty-five cents weekly, and up to a maximum of seventy cents, while the employer was to be charged from twenty cents to thirty-five cents weekly.

There was general criticism of the scheme, but when the Health Insurance Commission announced what it proposed to pay to the medical practitioners for their services, the medical men rose in revolt. They had not been consulted, and they decided to have nothing to do with the scheme. The government was facing an election, and hesitated to attempt coercion.

Whole Plan Is Suspended

So the whole scheme—which was already the law of the country—was suspended. Already \$83,900 of public funds had been expended, but the government announced a plebiscite.

This submission to the electors was the most confusing question ever placed before the British Columbia public. It was not for an endorsement of the scheme as announced, but an academic query: "Are you in favor of a comprehensive scheme of health insurance progressively applied?"

No person could explain just what was meant by that question. The British Columbia public is, on the whole, favorable to some plan of state medical aid, but the form of the question put upon the ballot paper was bewildering.

The confusion is more confounded by the fact that while about 30,000 more voted in the affirmative than gave a negative answer to the question, roughly 100,000 who went to the polls and voted for members of the legislature did not mark their preferences, according to the incomplete returns at hand.

So even with an apparent mandate to proceed with health insurance, the government is at a loss to know what form of scheme will be acceptable. —*New York Times*: —*NANA Press Dispatch*.

Squatter Army Wages Grim Battle for Life*

Hunger and Disease Stalk 50,000 Transients in San Joaquin Valley

Human squalor—a picture of approximately 50,000 persons driven to California by dust storms, drought, ill health and debts—awaits the visitor looking beyond the roadside today in the San Joaquin Valley.

A new chapter in American history is being written here. A battle for life, for food, health, homes and security is being waged by these hordes of transient indigents.

Pioneers Recalled

Within an hour the skeptic must admit he has seen disease, privation, filth and threats of epidemics. But he also must admit that he is seeing a fight for a job and a fight for a home similar to that of the pioneers in the South and Middle West in the last century. . . .

These people are not hoboes. They are not tramps. They are not foreigners. They are men destroyed financially in the Middle West and Southwest. Many are the Cotton Belt "white trash," but they are Americans.

Sympathy Aroused

Whether one visits the Federal Resettlement Administration's camps at Shafter and Arvin or the huddles of migrant indigents beside the roads throughout Kern County, one almost is struck dumb with sympathy.

Ranchers have provided eighty-six camps, ranging in size from a few dirty tents and tin shacks to the seventy-one bunkhouses, tents, trailer houses, railroad box and refrigerator cars on the DiGiorgio farms near Arvin.

The DiGiorgio layout includes separate quarters for Americans, Filipinos and Mexicans. But most camps throughout the county are populated by white Americans. . . .

Kern County has at least 10,000 transients from other states, relief and health officials estimate. They are the forgotten men of 1937. They have been brave enough, or perhaps disgusted enough, to leave their home states to fight for life in California.

No Starvation

There is no starvation—yet. Despite Works Progress Administration, State Relief Administration and Kern County Welfare Department rules to care first for permanent residents, these transients do occasionally receive financial aid and hospitalization. But funds are almost totally lacking to aid them adequately.

The men pick fruit and chop cotton. They earn an average of \$2.75 to \$3 a day. But they work, at the most, only half the days of the year. They must follow the crops during seasonal harvests throughout the San Joaquin Valley, and meantime their wives and children are falling prey to disease.

Prey to Disease

Go throughout Kern County—to Buttonwillow, Shafter, Wasco, Delano, McFarland, Famosa, Edison, Old River, Arvin, Panama or right on the outskirts of Bakersfield—and one sees and hears their woes.

* By Ray Zeman, *Los Angeles Times* staff representative.

Eleven cases of typhoid fever are now being treated. The county camp at Shafter was closed on July 10 and 108 families had to leave because flies in comfort stations threatened an outbreak of pestilence. Last night an open well near Shafter was closed because a family using it for drinking water is afflicted with eye disease.

Many Babies Die

Infant mortality caused by diarrhea and enteritis is triple the national average. Fifty babies died last year because of this.

Seven cases of poliomyelitis—infantile paralysis—are scattered throughout the county among the squatters. In-cipient tuberculosis develops easily.

Most camps have no baths, no showers, poor plumbing. The migratory workers drink from irrigation ditches at times and bathe in them. Typhoid easily results.

Governor Merriam, when he confers next week in Los Angeles with relief and welfare officials, has a problem appearing beyond solution.

Harry L. Hopkins, Works Progress Administrator, has offered sympathy but no financial aid. He contends the \$1,500,000,000 WPA bill recently passed does not provide the aid for transients which California asks.

A visit to these squatter camps leaves one aghast. One comes little more than 100 miles from Los Angeles and feels as if he might be in China, living among coolies.

Refuse to Return

Many of the transients are from Oklahoma, Arkansas, Missouri and Texas. Share-croppers, small farmers, a few tradesmen they are.

The county has offered to pay their expenses in returning them to their home states. Almost everyone refuses. There is nothing but drought and debt back there. Here there is a chance, at least during part of the year, to work.

There is a neighborliness among them. The worst time will be when cotton picking ends in September or October. County officials estimate that 22,000 more transients will be here then. After that—little or no work until March. Little or no money. Little food. Cheap tents crumpling under the rain. But a few loan enough to the others to prevent starvation. Will they do so next fall? Relief officials hope so. . . .

Officials Helpless

Health inspectors constantly check sanitary facilities, plumbing and drinking water. But they cannot stop insects multiplying. They cannot force the transient indigents to adopt cleaner living habits. They cannot put stockings on barefooted mothers walking on dusty paths. They do hope to get money to build five supervised transient camps. They do hope the Federal Resettlement Administration will build more.

*Wilful Underweight.**—Pride is one of the mainsprings of progress. But an illogical vanity is quite another matter. Vanity, among other things, inspires a comparatively large number of both men and women, particularly the latter, to deprive their bodies of the necessary amount of nourishing food. Thus to be guilty of a wilful, deliberate and pre-meditated sub-starving program is extremely foolish.

Made caloric-conscious a number of years ago and vitamin-alert during the past half-decade, there are thousands of persons who take their food intake too seriously. This offense frequently is predicated upon the desire to regain or maintain a stream-lined figure.

For instance, a year ago, a woman in her early thirties who was a "natural stout," decided it was high time to do something about it. So, following the too general trend of adopting dietary habits without professional sanction, she inflicted upon herself a cruel food regimen. Of course, she took off weight. However, in the process she literally starved herself. With a bodily resistance reduced to a pitifully low level, she succumbed to an acute illness—a vanity victim.

While this is an uncommon case, it nevertheless reveals a popular attitude on the reducing problem. Quite willing to seek authoritative advice on other subjects, many persons consider it totally unnecessary where diet is involved. In this connection, they are willing to be guided by the suggestions of friends or by their own judgment. Such an attitude can result in many serious consequences.

In short, whether one is thin and for vanity's sake desires to stay that way, or is stout and for the same reason wants to regain straight lines, the only safe practice is to seek and adopt professional advice. Wilfully to sub-starve for aesthetic purposes is a foolish and dangerous practice, and no doctor will recommend it.

* By Dr. I. C. Rigglin, State Health Commissioner, Virginia.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. X, No. 8, August, 1912

From Some Editorial Notes:

The A. M. A. Meeting.—The annual meeting of the American Medical Association at Atlantic City was a distinct success. The attendance was very good—within a small number of reaching the high water mark for Atlantic City meetings. A very large amount of work was done by the House of Delegates, but probably the most important single action taken was the decision to call a meeting of the secretaries of all State Medical organizations to be held in Chicago this fall, for the purpose of securing some more generally similar and satisfactory method of regulating membership. The President, in his address to the House of Delegates, made some recommendations that would have been far reaching and disastrous had they been carried out. But the House of Delegates wisely rejected these, and perhaps the most charitable thing to do is to make no further comment. Minneapolis is to be the place of the next meeting, the exact date not having as yet been determined. The officers elected are as follows:

President-Elect, Dr. John A. Witherspoon, Nashville, Tenn. . . .

Serious Horrors.—Bernard Shaw, in his preface to "Three Plays by Brieux," has some most pertinent reflections. "Nothing that is admittedly and unmistakably horrible matters very much, because it frightens people into seeking a remedy; the serious horrors are those which seem entirely respectable and normal to respectable and normal men." . . .

From an article on "The California State Tuberculosis Commission." By George H. Kress, M. D., Los Angeles, Chairman of the Commission.—The particular reason for giving the California State Tuberculosis Commission a place on this morning's program was to officially and briefly call to the attention of the members of the State Medical Society, somewhat of the nature of this newly formed State commission and some of the things it hoped to do.

As you all know, the last Legislature appropriated \$5,000, to be spent by a special tuberculosis commission to be appointed by the California State Board of Health, this commission to use this money to "ascertain the effects of localities, employments, conditions and circumstances on the health of those developing tuberculosis, and to determine the best means of eradication thereof." . . .

The State Board of Health appointed on the executive board of five, the following persons:

Dr. C. C. Browning of Los Angeles, Miss Katherine Felton of San Francisco, Dr. R. G. Broderick of San Francisco, Mr. A. Bonnheim of Sacramento, Dr. George H. Kress of Los Angeles, Chairman. . . .

From an article on "Rabies, and Its Present Status in California." By Wilbur A. Sawyer, M. D., Director of the Bureau of the Hygienic Laboratory of the California State Board of Health, Berkeley.—Efforts to check the spread of rabies, or hydrophobia, among the dogs of California are greatly hampered by the difficulty in obtaining authoritative statements of fact regarding the present situation. Many controversial articles and conflicting theories are being read and discussed, and it is no wonder that the public and, to a large extent, the medical profession of California are unaware of the true state of affairs. This article will attempt to present the facts needed by those who are trying to check the spread of the disease among dogs and to make its transmission to people impossible.

The early part of the present epizootic was reported by Black and Powers [Health Officers of Pasadena and Los Angeles].

(Continued in Front Advertising Section, Page 19)

†This column strives to mirror the work and aims of colleagues who bore the brunt of Association work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M. D.
Secretary-Treasurer

BOARD PROCEEDINGS

At a regular meeting of the Board of Medical Examiners held in Native Sons Hall, San Francisco, June 28 to July 1, inclusive, approximately 175 applicants wrote the examination, including approximately twenty chiropractors and one drugless practitioner.

Eighteen licentiates charged with various infractions of Section 14 of the Medical Practice Act, were called for hearing, with the following results:

Baker, Robert V., M. D., was on June 29, 1937, found guilty and placed on probation for five years.

Cary, Frank T., M. D., charged with conviction of violation of the Harrison Narcotic Act, was on June 30, 1937, revoked.

Chernyh, Sergey N., M. D., cited because of his conviction of violation of the State Narcotic Act, was on July 1, 1937, placed on probation for two years.

Gardner, Henry L., M. D. (initiated January 6, 1933), continued to the October, 1937, meeting.

Long, Oscar Charles, M. D., convicted of violation of the Harrison Act; conviction affirmed June 7, 1937, by the United States Circuit Court of Appeals, has his case continued to the Sacramento meeting of the Board, awaiting filing of a remittitur.

Long, Samuel C., M. D., alleged illegal operation. Revoked July 1, 1937.

Long, Thomas Sherman, M. D., charged with use of fictitious name, was on July 1, 1937, placed on probation for a period of five years.

McLellan, Gordon Lawrence, M. D., charged with narcotic dereliction. Revoked July 1, 1937.

Niemann, Theodore H., M. D., charged with violation of probation re narcotics. Revoked July 1, 1937.

Reorda, Caterina (midwife), charged with practicing beyond the limitations of her midwife license. Revoked June 30, 1937.

Steddon, Francis, M. D., narcotic dereliction. Revoked July 1, 1937.

Teepell, William, M. D., use of fictitious name. Probation for five years, July 1, 1937.

Tweedie, Arthur M., M. D., violation of probation re narcotics. Revoked June 30, 1937.

Watts, George E., M. D. Second complaint, abortion, dismissed June 29, 1937, because of his death May 20, 1937.

Whiteside, Harold H., M. D., June 29, 1937, guilty as charged. Penalty deferred.

Williams, Edward Huntington, M. D., conviction of violation of Harrison Act affirmed June 30, 1937. Probation two years without narcotic permit or privileges.

Wyatt, Thomas D., M. D., alleged illegal operation. July 1, 1937, continued to October meeting.

The license of Robert J. McDory, M. D., revoked July 15, 1926, was on July 1, 1937, restored.

News

"Dr. F. N. Folsom was arrested here today on a charge of violating the State Narcotic Laws. A. J. O'Ferrall, State Narcotics Agent, who swore to the complaint, said Doctor Folsom was accused of writing prescriptions for narcotics under fictitious names." (Associated Press Dispatch, dated Santa Rosa, June 17, printed Sacramento Union, June 18, 1937.)

"Four persons, all charged with conspiracy to commit an illegal operation, were found guilty by a jury yesterday in the court of Superior Judge Sylvain Lazarus. The four, who will be sentenced on Tuesday, were Minerva Geddes, Mr. and Mrs. Rudolph Zoffel, and Mrs. Eland Swindell. The quartet was arrested July 16, 1936, when a police homicide detail, acting on information from the sister of a woman who died as the result of an illegal operation, raided

(Continued in Front Advertising Section, Page 22)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.